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ABSTRACT

While California has evolved the elements of a strong and responsive mental health service delivery system based on a statutory partnership among the executive office, local jurisdictions, and citizens, many groups of persons in need of mental health services remain underserved. Such is the plight of the racial/ethnic minority people, whose environmental circumstances place them at high risk and whose differences are not compatible with the traditional class and culture bound system of mental health care. To solicit public testimony on the mental health needs of ethnic and racial minority groups, public hearings were conducted during 1978 in Fresno, San Francisco, El Centro, and Chico. Recommendations emerging from the hearings to enhance the quality of service include recruitment of bilingual/bicultural minority staff, in-service training on cultural differences of clientele, community education, inter-county cooperation, linking mental health services with other available social services, and enforcement of mandates and legislation. The report presents issues and concerns identified, the hearing notices, protocol, summaries of verbal and written testimony, correspondence, and other documentation, including tabular data on California's minority populations. (NEC)

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Multi-Cultural Issues In Mental Health Services: Strategies Towards Equity

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Report Prepared And Presented By The Citizens Advisory Council To Members Of The Legislature, Governor Edmund G. Brown, Jr., Secretary Of Health, Education And Welfare, Mario Obledo, And Director Of Mental Health, Dale Farabee.

October, 1979

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Multi-Cultural Issues In Mental Health Services: Strategies Towards Equity

State of California
Health and Welfare Agency
Department of Mental Health
Citizens Advisory Council

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FOREWARD

California has evolved the elements of a strong and responsive mental health service delivery system. The California system statutorily mandates a partnership among the executive office, local jurisdictions, and citizens. This partnership is exercised through the working relationships among the Department of Mental Health, the Conference of Local Mental Health Directors, and the Citizens Advisory Council.

Yet in the rich and diverse multi-cultural environment that is California, many groups of persons in need of mental health services remain underserved. Such is the plight of racial/ethnic minority people of color, whose environmental circumstances place them at high risk and whose differences are not compatible with the traditional class and culture bound system of mental health care.

In June, 1977, five minority individuals were appointed

by Governor Edmund G. Brown, Jr. to the Citizens Advisory Council. That same June the Citizens Advisory Council formed its Services to Minorities Committee, and pledged to support the work of that committee to improve the status of mental health services to minority people of color in California.

A moving and positive force in our work was Dr. Noel Hernandez Morrell, a child psychiatrist. An active committee member, Noel was a strong advocate for the needs and concerns of the culturally and linguistically different, and for children, the hope of our future.

To his memory, we dedicate our work.

Carmen Carrillo, Ph.D.
Chairperson

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I. INTRODUCTION

The Citizens Advisory Council for the State Department of Health established the Services to Minorities Committee to review the provision of mental health services to minorities in the state of California and to make recommendations which would enhance the quality of those services. In an effort to determine the availability of services to minorities and gather recommendations from the minority communities themselves, the committee conducted public hearings throughout the state on services to minorities.

The public hearings were conducted at Fresno (April 19, 1978), San Francisco (May 17, 1978), El Centro (June 23, 1978), and Chico (July 26, 1978). The purpose of the hearings was to solicit public testimony, both oral and written, on the mental health needs of ethnic and racial minority groups in California. At the conclusion of the hearings, the committee was charged with reviewing the testimony received and with making recommendations to the Citizens Advisory Council on the guidelines which should be developed and utilized by counties and the Department of Mental Health in respect to the planning, implementation and funding of mental health programs and services to minorities.

The hearings focused on the following issues:

1. The mental health needs of racial and ethnic minority groups.

2. The manner in which the mental health needs of racial and ethnic minority groups could be met with a focus on the types of programs and/or services, facilities, staff composition, staff capabilities, personnel training, funding levels, consumer input, and other issues related to service delivery.

3. Whether racial and ethnic minorities have access to quality care through the county services.

4. Whether programs and services are culturally relevant and easily accessible.

5. Whether the county meets the service needs of its demographic population.

6. The criteria and/or standards which should be developed to measure whether and to what extent, the mental health needs of racial and ethnic minorities have been met.

7. The means of participation for racial and ethnic minorities in counties' mental health planning process.

The public hearings format was necessitated due to the overwhelming lack of hard, statistical data with respect to the field of services to minorities. The committee, therefore, determined to conduct public hearings in order to collect further information. The committee was concerned that the public hearing format be utilized most efficiently to collect data that would describe the needs of minorities, and therefore developed the above-referenced areas of concern. Notice of the hearings was mailed to individuals, organizations, and local mental health centers throughout the state. Notice of the hearings was also submitted to local newspapers, as well as to ethnic publications. The notice urged all persons having some knowledge in the area to submit testimony, either orally or in writing. The hearings were held in various parts throughout the state in an attempt to make the hearings accessible to persons throughout the state. A court reporter recorded

the full day of hearings at each hearing site. In addition, a translator was present at all times to enable persons lacking facility in the English language to testify. Following the hearings, a full transcript of the proceedings was prepared for study by the committee. During the course of the hearings, the committee heard testimony from over seventy-four (74) individuals. Many more concerned individuals attended the hearings in support of witnesses, and to learn from the participants. Written testimony was also submitted to the committee.

This report on the mental health service needs of California's minority population is derived wholly from the testimony presented to the Services to Minorities Committee at the statewide public hearings.

II. OVERVIEW: ISSUES AND CONCERNS

Of primary concern to committee members is the enforcement of existing state and federal laws and regulations concerning the provision of services to minorities. Much of the testimony indicated that current policies and practices of many counties may be out of compliance with existing law.

A recurrent theme in the testimony presented was the impact of the Jarvis-Gann initiative, popularly known as Proposition 13, on local mental health services agencies' work force and provision of services. The financial cutback severely limits the expansion of services, threatens existing services, and will severely impact the existence of a minority work force should layoffs occur. Innovative methods of dealing with this problem will have to be developed if the potentially drastic cut of existing services to minorities is to be avoided.

The issue of improving mental health services for minorities has been addressed on both the national and local levels.

Most recently the President's Commission on Mental Health (1978) established panels and task forces to address the needs of minority groups in the United States. Overall, the findings reflect a growing national concern on the provisions of equitable services to minorities who have been historically underserved by the mental health system. The problems of minority access to mental health services are recently being addressed by government at each different level:

A. Federal Level

In 1975 the Community Mental Health Center Amendment Act was passed. This law states that in areas where there are substantial minority populations, services are to be provided in the language and cultural context appropriate for such clients. The guidelines for CMHC services to minorities are potentially far-reaching: for instance, guidelines provide that the CMHC should implement programs, policies and procedures which will assure that all board members and staff will give specific attention to the identification and elimination of practices which impede the delivery of effective and equitable services to minorities. Examples of procedures and practices which should be examined and modified as indicated include: staff behavior at intake;

criteria used to determine which staff are assigned to work with minorities; referral determination; diagnostic procedures, including the use of culturally biased tests; and treatment modalities (Guidelines, PL 95-83, Dec. 1977).

B. State Level

Services to minorities has been designated as one of the top four priorities for the past two years. In October, 1977, the State Department of Health issued a policy and intent statement regarding services to minorities. This statement addressed not only affirmative action hiring of ethnic minority staff but also addressed such issues as:

1. Minority needs assessment which looks at the special characteristics of minority population to get an indication of need for increases or different services to minorities;

2. Existing mental health programs specifically designed to meet the mental health needs of ethnic minorities;

3. Translation of critical forms into languages spoken by ethnic minorities who constitute a significant proportion of the population;

4. Data collection regarding utilization of services and demographic characteristics of staff, and other pertinent information.

C. County Level

Services to minorities has recently also been designated as a top priority at the county level and the Mental Health Advisory Boards (MHAB) have been required to establish local committees concerned with services to minorities (Welfare & Institutions Code, 5606.1).

Despite the existence of these and other laws to ensure equal access for minorities to mental health services, the participation rate of minorities in the mental health system both as consumers and providers, generally has been below average (depending on ethnic group and geographic area). It is imperative that every effort be made to enforce existing laws to assure equal access to available mental health services to all persons regardless of race or ethnic background.

III. SUMMARY OF PROBLEMS IDENTIFIED

A. There is an under-utilization of mental health services by minority populations.

B. There is a need for research on what constitutes accessible services to minorities. A needs assessment is necessary to determine how to best approach the problem of each group.

C. There is a lack of culturally relevant services available to minority populations (what is culturally appropriate differs with each minority group).

D. There are language barriers precluding access to available services to limited or non-English speaking populations. Frequently community workers provide service to these populations, leading to a two-level system of care. Another unsatisfactory alternative

is where patients are seen through an interpreter. Either alternative can result in mis-diagnosis and results in inferior treatment.

E. Geographic accessibility to services presents a problem in rural areas especially for senior citizens and low-income minority persons.

F. There is a lack of preventative care services for minorities.

G. There is no training in multicultural awareness available and required in institutions of higher learning which train the core disciplines (psychiatry, psychology, nursing, and social work).

H. There is a lack of minority staff at the professional and administrative levels to provide services to minorities.

I. There is sporadic recruitment by local counties of minority personnel.

J. The fiscal cutbacks as a result of Proposition 13 have had an impact on services to minorities as well as lay-offs of minority personnel.

K. Provisions in local county plans are not reviewed and enforced by the State Department of Mental Health.

IV. SUMMARY OF RECOMMENDATIONS

A. Relevant, accessible services to the minority populations of the state should be made available.

B. Recruitment of minority staff, bilingual/bicultural where appropriate, should be a local and state priority.

C. In-service training programs to train minority and non-minority staff on the cultural differences of clientele should be required of local mental health programs and enforced by appropriate state agencies.

D. Community education on existing and available mental health services should be encouraged.

E. Outreach programs for minority mental health consumers should be instituted by local mental health programs.

F. Research on culturally appropriate services for minorities should be undertaken.

G. The sharing of responsibility by counties for development and maintenance of specialty programs where a single county does not have the ability to sustain such programs should be encouraged. Inter-county agreements to deliver comprehensive services to some minority communities would ensure that some mental health services rather than no service be provided.

H. Mental health service centers should be closely linked to available social services to ensure that services from the generic agencies (housing, education, employment, rehabilitation) are utilized to assist those individuals who need these other services.

I. Successful innovative programs dealing with minority mental health needs should be institutionalized into existing mental health systems.

J. Local Mental Health Advisory Boards should be closely monitored to insure their compliance with recent law requiring affirmative action and recruitment of minority members.

K. The establishment of language skills criteria for bilingual mental health personnel should be developed to ensure adequate linguistic ability by individuals in bilingual positions.

L. State technical assistance should be provided by appropriate state agencies to local counties.

M. Training in multicultural awareness should be available and required in educational institutions and required in state licensing of mental health personnel.

N. Concerning post-Proposition 13 problems: minority services should be integrated into the civil service systems and, where necessary, minority services should be contracted out; local counties should institute policies of considering affirmative action equal with seniority in employment layoffs.

O. Enforcement of mandates and legislation relevant to mental health services to minorities to ensure equal access to available services should be undertaken.

V. DISCUSSION OF PROBLEMS

A. <u>There is an under-utilization of mental health services by minority populations</u>.

<u>Discussion</u>: The committee received testimony which cited the under-utilization of mental health services by all minority populations. The under-utilization of services is due to various factors:

1. <u>Geographic Inaccessibility</u>. Very often mental health services are unavailable to minority populations because they are located far from the individual's home. This was a frequently cited problem in rural areas where the lack of transportation heavily burdened the minority and/or low-income population. Testimony indicated that the accessibility to services was also a problem in urban areas where public transportation was sparse or inadequate or where mental health facilities were located in areas far from the potential consumer's residence;

2. <u>Class and Cultural Barriers</u>. The lack of culturally sensitive and appropriate

services was often cited as the reason for minority under-utilization of mental health services. The failure of local mental health systems to provide either services designed for and relevant to the specific needs of its minority populations or staff trained in the delivery of relevant services resulted in few minorities availing themselves of existing services. Testimony indicated that where pilot programs which focused on the specific needs of a particular minority were conducted, the provision of relevant services increased the particular minority's utilization of those services in a dramatic manner;

3. Language Barrier. Many limited or non-English speaking minorities were unable to utilize mental health services due to lack of bilingual/bicultural staff. This language barrier effectively precluded language minority individuals from utilizing existing mental health services.

B. There is a need for research on accessible services to minorities.

Discussion: The committee received testimony concerning the need for research on what constitutes accessible services to minorities. Existing data on minority services is too sparse to assist local counties in the development of broad-scale programs for minorities. In-depth research and a needs

assessment is necessary to determine how to best approach the problems of each particular minority group. Basic and applied research would increase the scientific understanding of the needs of each minority group and recommendations for the diagnosis, treatment and prevention of mental illness among minorities.

C. <u>There is a lack of culturally relevant services available to minority populations</u>.

<u>Discussion</u>: Testimony received by the committee indicated that there is an almost total lack of culturally relevant services available to minority populations. The few culturally relevant programs available in the state were in urban areas. Apart from this handful of model programs, the vast majority of counties throughout the state lacked culturally relevant services for their minority populations. Each minority group expressed the need for mental health services that were culturally appropriate. Clearly, what is "appropriate" differs with each minority group. The failure by local mental health service agencies to provide culturally appropriate services is due to several factors: the state's

lack of enforcement of state and federal law mandating the provision of equitable services for minorities; the failure of the state to assist financially local counties in developing culturally appropriate services where fiscal considerations were the reason for the county's inaction; inadequate county resources to encourage the local development of specialized relevant minority services in areas of high minority populations. The failure of local counties to develop minority services is particularly onerous in light of the post-Proposition 13 cutbacks since most counties have not integrated such services into their regular mental health system. Therefore, it is unlikely that such services will be provided to the minority populations without specialized funding or state and federal intervention requiring the development of minority services.

D. Language Barriers Preclude Access To Available Services By Limited Or Non-English Speaking Persons.

Discussion: A very high percentage of California residents are limited or non-English speaking; this is particularly true for certain ethnic groups, particularly exemplified by the

Latin American and Asian Pacific populations. The failure of mental health service agencies to provide bilingual personnel at in-take and treatment levels affects the availability of these services to limited or non-English speaking persons.

Testimony stated that the presence of an interpreter (either a friend of the client or third party support staff in the agency) to interpret between the client and staff was not an adequate manner of addressing the language problem. Frequently, the interpreter does not have the linguistic ability nor the mental health background to perform in a truly adequate manner. Additionally, the client's confidentiality is not protected. The result is that limited or non-English speaking persons receive services which are inferior to the services received by the English speaking population. Finally, at mental health agencies where no interpreter services are provided, the limited or non-English speaking persons seeking mental health services are not provided with any services.

E. Geographic Accessibility To Services Presents A Problem In Rural Areas, Especially For Senior Citizens And Low-Income Minority Persons.

Discussion: A problem specific to rural areas as set forth in the testimony is that of geographic accessibility to available mental health services. Accessibility becomes a problem in rural areas due to the spread out character of the population and the frequently centralized nature of the available mental health services. Accessibility to services becomes even more difficult where, as in most rural counties, there is an inadequate public transportation system. The problem is especially severe for senior citizens and low-income minority persons who frequently do not have access to transportation on a regular basis. Geographic inaccessibility results in a lower utilization rate for these populations.

F. There Is A Lack Of Preventative Care Services For Minorities.

Discussion: Testimony raised the problem of local counties' failure to develop preventative care services for minorities. Preventative programs would include education

and information programs on mental health. Currently, there are no materials available that are culture specific and linguistically relevant. This is critical in view of the fact that the area of prevention deals with the application of concepts derived from a white middle-class perspective and thus, in most cases, is inapplicable to minority populations.

G. <u>There Is No Training In Multicultural Awareness Available And Required In Institutions Of Higher Learning Which Train Core Disciplines (Psychiatry, Psychology, Nursing, and Social Work)</u>.

<u>Discussion</u>: The failure of academic institutions to train professionals in multicultural awareness results in the matriculation of professionals who lack training to enable them to work with over 30% of California's population. Since such specialized training has not been provided as part of the professionals' training, the burden is shifted to local counties to provide such in-service training to its staff. Curricula in multicultural training should be available and required in all graduate and undergraduate schools providing training in core mental health disciplines.

H. There Is A Lack Of Minority Staff At The Professional And Administrative Levels To Provide Services To Minorities.

Discussion. A major problem recurrent throughout the testimony is the lack of minority mental health personnel and bilingual/bicultural personnel in service areas with a high proportion of minority or non-English speaking persons. The lack of minority-bilingual staff was a problem in both rural and urban areas; testimony from rural areas indicated that the recruitment of minority-bilingual staff to rural areas was even more difficult than recruitment to urban mental health centers.

Testimony indicated that there were even fewer minority persons at the administrative and public policy making levels. The lack of minority administrative personnel affects the policy, program, and administrative decisions made concerning local mental health services. In areas with a high minority population, the existence of minority administrative personnel could lead to more relevant, accessible services for the minority population of the county.

Minority and bilingual personnel, when available, are most frequently located in clerical, supportive staff and para-professional levels. While the recruitment of para-professional staff by mental health service agencies is encouraged, the testimony indicated that minority para-profes-

sionals do not and cannot provide the quality of services that minority professional staff are capable of providing, and therefore, the existence of such para-professional staff should not lessen the burden on the counties to recruit minority bilingual professional and administrative staff.

I. There Is Sporadic Recruitment By Counties Of Minority Personnel.

Discussion: The committee heard testimony stating that the lack of minority and bilingual personnel was intensified by counties' sporadic recruitment practices of minority and bilingual personnel, and the absence of assertive affirmative action plans with goals, objectives, and timetables.

J. The Fiscal Cutbacks As A Result Of Proposition 13 Have Had An Impact On Services To Minorities As Well As Layoffs Of Minority Personnel.

Discussion: The budgetary limitation of local counties' mental health programs since the passage of Proposition 13 has had a dual affect on the mental health system concerning

minorities:

1. Services. The fiscal cutbacks affect the availability of services to minorities through existing city-wide civil service programs and through non-civil service contract programs;

2. Employment. The fiscal cutback in many mental health programs will result in a layoff of personnel of existing programs, and fiscal reductions in contract programs. Where such layoffs are done according to the employee's strict seniority on the job there will be a disproportionate impact on the minority and female employees affected since they, by and large, have less seniority than non-minority employees. Clearly, the result of the situation will most heavily impact the minority communities of local counties who are the recipients of these services.

In many counties throughout the state minorities have not been recipients of mental health services either through the existing mental health systems or through special contract programs. The effects of these past failures to provide services to minorities will be multiplied when the budgetary cutbacks result in a decrease of existing services. It will become increasingly difficult to develop and initiate new programs under the new fiscal austerity. Therefore, where programs have not existed or have only recently existed, the likelihood of maintaining or increasing services to minorities seems remote. Additionally, the layoff of minority

personnel will weaken the availability of existing mental health services to minority populations.

K. Provisions In Local County Plans Are Not Reviewed And Enforced By The State Department Of Mental Health.

Discussion: State and federal statutory requirements concerning the provision of services to minorities are becoming increasingly common. Many of these provisions concern data keeping requirements, provision of equitable services, minority representation on Mental Health Advisory Boards, and other provisions for the improvement of minority mental health services. Additionally, state (Government Code section 11135) and federal (Title VI, Civil Rights Act of 1964) anti-discrimination laws prohibit discrimination on the basis of race and national origin by programs receiving state or federal funds.

The existence of these provisions concerning minorities is indeed encouraging. However, a failure to enforce the spirit in letter of the law in effect allows counties to continue their inequitable services to their minority populations.

Testimony indicated that there is a need for enforcement of mandates and legislation for relevant mental health and other human services to minorities. The enforcement of these laws is best handled by the state and mental health agencies, rather than private individual citizens. Many county mental health plans, because required by federal and state law, contain anti-discrimination provisions and affirmative language concerning service to minorities. Testimony indicated these provisions were infrequently followed by county mental health officials and should be enforced by state and/or federal officals.

VI. DISCUSSION OF RECOMMENDATIONS

A. Relevant, Accessible Services To The Minority Populations Of The State Should Be Made Available.

Discussion: A common theme among those giving testimony regardless of racial or national origin/background was that adequate services to the minority populations of the state is not presently available in rural or urban areas. A strong recommendation was made to develop and initiate relevant, accessible mental health services for all minority groups. Relevant services refer to those services which take into consideration the minority person's cultural and class background as well as language barrier, if any. As with other special subpopulations, most obviously, children and the elderly, the mental health system must develop service methods certain to reach and succeed with minority persons. There are only a handful of model programs throughout the

country which have begun to develop such services. An effort must be made by local and state level mental health administrators to support and to continue these minority programs where they are successful, to assist in improving minority programs that are moderately successful and to take steps necessary to create such programs where none exist.

Accessible services refer to those services that are available not only geographically, but also culturally and psychologically. Testimony indicated that geographic accessibility was a problem in both rural and urban areas. Rural minorities, especially the elderly, found it difficult to gain access to mental health services located miles away. Among suggestions for the rural population were to decentralize services throughout the service area offering services in varying locations; to dispatch mobile units with mental health personnel to reach especially isolated areas and/or elderly or disabled persons; to assist in providing needy persons with necessary transportation to mental health facilities. Urban minorities suffered similar problems, though not necessarily as aggravated as those suffered in rural areas. Among the suggestions to improve geographic accessibility for urban minorities was the development of neighborhood programs located in minority populated areas and outreach

to minority neighborhoods by para-professionals for initial mental health service contact.

Cultural accessibility refers to the provision of services by personnel aware of and sensitive to the minority consumer's cultural background. This includes the provision of service and materials written in the language of monolingual non-English speaking persons. Mental health services can seek to develop services that are culturally accessible by recruiting and retaining bicultural and/or bilingual personnel to provide direct services, and by providing existing non-minority mental health personnel with in-service training programs. Such programs will make personnel sensitive to issues and problems of minority consumers and to successful treatment approaches.

Psychological accessibility refers to the delivery of services in a manner conducive to successful rapport between the consumer and the provider. Too often a minority person experiences negative encounters with the mental health system when such services are provided in alien, sterile environments, and where the personnel is uncaring or hostile. Institutional racism and its overt and subtle practices must be eliminated so as to provide the minority consumer of mental health services with a satisfactory encounter.

B. Recruitment Of Minority Staff,(Bilingual/Bicultural Where Appropriate), Should Be A Local And State Priority.

Discussion: Of primary importance in assuring the provision of equitable mental health services to minorities is the recruitment and employment of minority personnel. This includes minority staff in public contact positions as well as in para-professional, professional and administrative positions. Among suggestions to improve recruitment efforts were the following:

1. Counties should establish fellowship programs with local academic institutions assisting graduate minority students. Students would work with county mental health programs on a part-time basis while enrolled and would become full-time employees upon graduation;

2. The State Department of Mental Health should assist counties in their recruitment efforts by disseminating job listings to various agencies and to individuals. Recruitments of minorities should be standardized and not left solely to local jurisdictions;

3. Counties that cannot compete with the private sector and some public employers in paying higher salaries, should attract minority professional by offering the available salary in exchange for a three or four day work week. This would enable the professional to supplement the lower salary with income from outside activities;

4. The State Department of Mental Health should maintain current lists of minority persons available for employment. This would simplify the counties' recruitment efforts;

5. Counties should offer salary incentives to attract clinicians who have specialized skills in dealing with minority populations, such as the chronically ill, the elderly and children in need of psychiatric intervention;

6. The State Department of Mental Health should assist rural counties in the recruitment of minority clinicians by subsidizing the counties and thereby enabling them to offer financial incentives to minority clinicians to relocate in rural areas;

7. The various state licensing boards should re-examine their policy towards foreign professionals who have been licensed in other countries. Frequently foreign professionals have the language ability and cultural background to provide mental health services to minority groups. These foreign licensed professionals should be given preferred treatment by state licensing boards;

8. "Minority points" should be given to minority persons competing for civil service positions who have special skills in working with the minority community. These points would be similar to veteran points presently provided to veterans. Minority points would increase the number of minority persons working within the local mental health programs.

C. In-service Training Programs To Train Minority And Non-minority Staff On The Cultural Differences Of Clientele Should Be Required Of Local Mental Health Programs And Enforced By Appropriate State Agencies.

Discussion: Testimony indicated that frequently personnel have not had training that enabled them to deal with the problems of the minority mental health consumer. To offset this problem counties should initiate in-service training programs to train all staff on the cultural differences of minority clientele in the service area. To assure effectiveness, the in-service training component should be more extensive than a one-time session. To assist counties in this endeavor, the Department of Mental Health should develop materials for the in-service training which could be utilized by county or state personnel.

D. Community Education On Existing And Available Mental Health Services Should Be Encouraged.

Discussion: A frequent problem in minority communities is the under-utilization of existing mental health services. Testimony from laypersons and mental health professionals alike attributed a portion of minorities' under-utilization

of the services to the lack of education on the services available from the present mental health system. Local mental health programs should develop written materials (bilingual materials where service area contains over 5% minority limited or non-English speaking persons) and should disseminate information via local radio and television stations about mental health programs and activities. Community education programs would serve to educate minority communities on the benefits available at local mental health programs and lessen the stigma attendant to being in need of such services. Many laypersons do not associate common symptoms such as stress or anxiety as problems that can be addressed by mental health professionals.

E. Outreach Programs For Minority Mental Health Consumers Should Be Instituted By Local Mental Health Programs To Overcome Under-utilization Of The Services.

Discussion: Outreach programs instituted by county mental health programs can use, among other things, the community education activities discussed above to increase minority utilization of existing mental health services. Outreach programs should be developed by and for minority

persons (bilingual and bicultural persons where appropriate). The focus of the program should be to educate minorities on available mental health services and to refer individuals to the appropriate services when necessary. The method that each program would develop for its outreach depends on the community--urban or rural--as well as on other factors. Outreach programs are a necessary tool to increase minority utilization of mental health services.

F. Research On Culturally Appropriate Services For Minorities Should Be Undertaken.

Discussion: State and local mental health systems must establish as a priority in-depth research and needs assessments on minority populations in order to determine how to best approach the problems of each group. Existing data on minority services has been sparse; however, as of 1978, each county is required to collect basic data on the racial/national origin of its consumers; percentage of minorities in its service area; number of minorities on mental health program staff; and other data of interest on minority group usage of services. Some of this information will assist in

determining how each county is serving its minority populations. However, local counties required County Plan data on minorities is only a beginning. Needs assessments on local minority communities must be undertaken by local counties. In-depth research should also be initiated, especially by the State Department of Mental Health, to increase the scientific understanding of each minority groups' particular mental health problems and to make recommendations for the improved diagnosis, treatment and prevention of mental illness among minorities.

G. <u>The Sharing Of Responsibility By Counties For Development And Maintenance Of Specialty Programs, Where A Single County Does Not Have The Ability To Sustain Such Programs, Should Be Encouraged</u>. <u>Inter-county Agreements To Deliver Comprehensive Services To Some Minority Communities Would Ensure That Some Mental Health Services Rather Than No Service Be Provided</u>.

<u>Discussion</u>: Testimony indicated that in rural counties or in counties with a small number of a particular minority group (e.g., Vietnamese) the local mental health program was unable to develop and maintain specialty programs to serve some or any of its resident minorities. The county's inability to provide these services was due mainly to the

lack of resources, personnel or expertise. Frequently, a minority consumer would travel to another county to avail him/herself of that county's specialized minority mental health services and/or personnel. To alleviate these problems, inter-county agreements to deliver comprehensive services to minority communities should be developed and encouraged by the State Department of Health. These agreements between participating counties would share the expense and staff needed for specialty programs. As a result, small or scattered minority communities would have their needs addressed by nearby mental health programs.

H. Mental Health Service Centers Should Be Closely Linked To Available Social Services To Ensure That Services From Generic Agencies (Housing, Education, Employment, Rehabilitation) Are Utilized To Assist Individuals Who Need The Services.

Discussion: Frequently, minority persons' mental health problems stem, in part, from social factors: poverty, unemployment, and poor housing. At these times professional mental health assistance is needed, as well as assistance from local social service agencies. Mental health programs should develop a linkage with social service agencies so that referral to these

agencies, when appropriate, can be made. Social service referrals by mental health programs will assure that minority persons obtain needed assistance from these various sources.

I. Successful Innovative Programs Dealing With Minority Mental Health Needs Should Be Institutionalized Into Existing Mental Health Systems.

Discussion: Testimony indicated that the few existing innovative mental health programs in the state are not linked to the civil service system. Rather, these innovative programs are independent contract programs with a specific purpose and limited time span. Where contract programs specializing on minority mental health problems are successful, the county mental health program should incorporate the contract program into the county system. This action will serve to institutionalize the specialty program and ensure its continued funding and, therefore, its activities. The failure of local counties to incorporate contract programs will result in the phasing out of successful minority programs due to fiscal or other reasons. The maintenance of these programs is essential to the minority communities where the contract programs are established.

J. Local Mental Health Advisory Boards Should Be Closely Monitored To Ensure Their Compliance With Recent Law Requiring Affirmative Action And Recruitment Of Minority Members.

Discussion: Local Mental Health Advisory Boards are required, under state law, to have minority group representatives and to create minority mental health committees to assist the MHAB in evaluating programs and determining needs vis a vis the minority community. The law was effective January 1, 1979, and applies to all MHAB vacancies filled after that date. Mental Health Advisory Board membership is reported in each County Plan submitted to the State Department of Mental Health.

It is important that the Department re-affirm this priority of minority MHAB membership to the local counties and seek to enforce the mandate by reviewing the counties' compliance upon receipt of the counties' 1979-1980 County Plan. Any county MHAB not in compliance at this date should be required to set forth the reasons for non-compliance and to furnish the steps it will take to increase minority MHAB membership. A similar state review should occur concerning each county's establishment and maintenence of a minority mental health committee to advise the MHAB on minority mental health concerns.

K. The Establishment Of Language Skills Criteria For Bilingual Mental Health Personnel Should Be Developed To Ensure Adequate Linguistic Ability By Individuals In Bilingual Positions.

Discussion: The need for bilingual mental health personnel is obvious in communities where 5% or more of the population is limited or non-English speaking. Many counties assure the hiring of bilingual personnel through the use of bilingual waivers, separate bilingual classifications and similar mechanisms. Few counties, however, establish standards for bilingual ability to assure a competent level of linguistic ability on the part of the job applicant.

Clearly, employing persons who are not linguistically competent is of little or no assistance to the limited or non-English speaking mental health consumer. Local counties must establish standards for certification of linguistic ability to assure competent bilingual personnel. The State Department of Mental Health should assist in developing standardized methods for certification. Only truly bilingual persons should be employed in positions requiring competence in a second language.

L. State Technical Assistance Should Be Provided By Appropriate State Agencies To Local Counties.

Discussion: Local county mental health programs frequently lack the expertise or financial ability to develop specialized minority programs. The State Department of Mental Health should use its resources to set up a specialized office on minority mental health to assist local counties in improving their services to the minority community. The state office could, inter alia, assist in the language translation of forms, community education materials and other documents; develop a statewide list of minority and bilingual mental health professionals for local county use in recruiting of personnel; establish language certification standards for county use; develop models for in-service training of minority and non-minority personnel on the cultural aspects of minority mental health consumers; assist local community groups in seeking and obtaining federal funding for specialized minority mental health programs; and initiate research on culturally appropriate mental health services for minorities.

The above list is by no means exclusive, but suggests areas in which the state's assistance and expertise would

be beneficial to local mental health programs. State level technical assistance would avoid county duplication of efforts in developing standards, personnel lists or in-service training. The overall result of such statewide assistance would be to improve greatly minority mental health programs.

M. Training In Multicultural Awareness Should Be Available And Required In Educational Institutions And Required In State Licensing Of Mental Health Professionals.

Discussion: Academic institutions which provide training in the core disciplines (psychiatry, psychology, nursing, and social work) should require that students take courses in multicultural awareness as part of the graduation requirement. Furthermore, curricula on multicultural awareness should be required by the state in licensing mental health professionals.

The Department of Mental Health's Health Training Center should establish these priorities: the training of minorities; the training of current center staff in multicultural awareness; contract with specialists in multicultural awareness to provide training.

N. Concerning Post-proposition 13 Problems: Minority Services Should Be Integrated Into The Civil Service System And, Where Necessary, Minority Services Should Be Contracted Out; Local Counties Should Institute Policies Of Considering Affirmative Action Equal With Seniority In Employment Layoffs.

Discussion: The spectre of Proposition 13 has resulted in severe threats to the provision of mental health services to minority communities. The budgetary cutbacks in existing programs will affect services to and employment of minorities.

Services. Minority services are frequently "contracted out" and as such are not insulated by the civil service system when programs are cut. To protect services to minorities, the programs should be integrated into the county mental health system as discussed previously in Recommendation I. Where minority programs must be "contracted out" the county must assure continued funding despite overall fiscal cutbacks. A failure to take this position will result in decreased services to the minority population since few minority programs are institutionalized into the mainstream mental health system where their continued existence is assured.

The fiscal cutbacks especially affect counties where no minority mental health programs have been initiated. These counties have cut back on their regular mental health services

and are unlikely to initiate "speciality" services in this era of austerity. State intervention is necessary in these counties to assure the equitable provision of mental health services to the minority population.

Employment. The employment of minorities within the mental health system is also certain to be affected by the budgetary cutbacks in the coming years. Minorities have been employed in local mental health programs only within the last ten years. As a result, minority personnel generally have less seniority than Anglo personnel within the civil service system. Therefore, in a strict seniority system, minorities are the first to be laid off when cutbacks occur.

Counties can take several steps to avoid a drastic reduction in their minority personnel. First, counties can institute policies of considering affirmative action, employee's special skills and departmental needs equally with seniority in determining employment layoffs. This will allow mental health administration to consider many factors, including the ability of its personnel to meet the service needs of its minority consumer population, when laying off employees. Such layoff policies are legal, so long as counties do not use race alone in making layoff determinations. Second, counties may retain bilingual personnel during employment

layoffs. Bilingual personnel are legally mandated in "public contact" positions in counties that have 5% or more minority populations having a primary language other than English. The director of the State Department of Mental Health, in a notice to all county mental health programs and personnel directors, dated June 13, 1978, has set forth this policy which allows county personnel departments to have merit system authority to treat bilingual positions separately.

The counties' legal obligations to provide equitable services to their minority populations and to employ minority civil service personnel are distinctly separate obligations mandated by federal and state law. Although services to and employment of minorities overlap--counties must take steps to assure the equitable provision of both services and employment to their minority populations.

O. Enforcement Of Mandates And Legislation Relevant To Mental Health Services To Minorities To Ensure Equal Access To Available Services Should Be Undertaken.

Discussion. Laws concerning the provision of mental health services exist at the federal, state and local levels. These legal mandates are potentially far-reaching if enforced

by federal and state agencies. The failure of local mental health programs to heed the law will assure a continuation of the inequitable provision of mental health services to the minority communities within the state.

The State Department of Mental Health should expand its Office of Civil Rights to ensure that adequate staff is available for the enforcement of state and federal statutory requirements. Each county's proposed County Plan for 1979-1980 should be reviewed to assess compliance with existing laws. If, upon review of the plan, non-compliance is found, sanctions must be levied against the county. The State Department of Mental Health's failure to take decisive action and sanction counties where necessary, will result in continued inequitable mental health services to the state's minority populations.

VII. CONCLUSION

The problems and recommendations concerning the provision of mental health services to California's minority population contained in this report are by no means exclusive. The written and oral testimony received and reviewed by the Citizens' Advisory Council's Services to Minorities Committee revealed an appalling lack of mental health services for the state's minorities. Surely, additional problems and recommendations exist--but the implementation of this report's recommendations would go far towards the equitable provision of mental health services to all persons. The Services to Minorities Committee hopes the Governor's Office, Legislature and Department of Mental Health will take leadership in redressing the problems outlined herein. The Citizens' Advisory Council is gratified to provide the tools with which to accomplish this task.

APPENDICES

Appendix I

Notice Of Public Hearings

STATE OF CALIFORNIA — EDMUND G. BROWN JR., Governor

CITIZENS ADVISORY COUNCIL

Established under Community Health Services Law

714 P Street
Sacramento, California 95814
(916) 445-2090

CHAIRPERSON
Carmen Castillo, Ph.D.

VICE-CHAIRPERSON
Armando Morales, D.S.W.
Noel K. Monroe, M.D.

Members
Governor Appointees
Robert LaMede-Williams, M.D.
General Medicine
David Flanagan, M.D.
General Psychiatry
Noel Hernandez Monroe, M.D.
Child Psychiatry
Carmen Castillo, Ph.D.
Psychology
Armando Morales, D.S.W.
Social Work
Ruth Ann Terry, R.N.
Nursing
Larry J. Thompson
Administrator, Patton Hospital
Dennis M. Hillmon
County Supervisor
Penin State Board
General Public

CHAIRMAN, SENATE RULES
Committee Appointees
Michael Eddy
Law
County Supervisor
James A. Keese
General Public

SPEAKER OF ASSEMBLY
Appointees
Manuba Harmon, Ph.D.
Sociology
Ernest W. Kluka, M.D.
Conference of Local Mental Health Directors
Lila Berman
General Public

EXECUTIVE SECRETARY
Robert L. Jackson

RECORDING SECRETARY
Jeanne Stubbs

NOTICE OF PUBLIC HEARINGS

The Services to Minorities Committee to the State's Citizens Advisory Council will conduct four public hearings on the dates and places listed below.

1. Wednesday, April 19, 1978
   Sheraton Inn
   2550 West Clinton Avenue at Highway 99
   Appollo Rooms One and Two
   Fresno, CA 93705
   (209) 486-3000
   10:00 a.m. to 5:00 p.m.

2. Wednesday, May 17, 1978
   Airport Hilton
   San Francisco International Airport
   Vintage Rooms 5, 6, 7 and 8
   San Francisco, CA 94128
   (415) 589-0770
   10:00 a.m. to 5:00 p.m.

3. Friday, June 23, 1978
   El Centro Community Center
   375 South First Street
   El Centro, CA 92243
   (714) 352-6861
   10:00 a.m. to 5:00 p.m.

4. Wednesday, July 26, 1978
   Holiday Inn
   865 Manzanita Court
   Chico, CA 95926
   (916) 345-2491
   10:00 a.m. to 5:00 p.m.

The purpose of the hearings is to solicit public testimony, both oral and written, on the mental health needs of ethnic and racial minority groups in California. At the conclusion of the hearings, the Services to Minorities Committee will review all testimony received and make recommendations to the Citizens Advisory Council on the guidelines which should be developed and utilized by counties and the Department of Health in their respective planning, implementation and funding of mental health programs and services to minorities.

The ultimate goal of the Council is to collect data and write a report on minority mental health needs and services from which policy and program recommendations will be made to the State Department of Health and County mental health programs.

All hearings will focus on the following issues:

- What are the mental health needs of racial and ethnic minority groups in your County?

- How can or should the mental health needs of racial and ethnic minority groups be met in your County. Please focus on the types of programs and/or services, facilities, staff composition, staff capabilities, personnel training, funding levels, consumer input, and other issues related to service delivery.

- Do racial and ethnic minorities in your County have access to quality care through the County Services? Please address all aspects of accessibility.

- Are the programs and services culturally relevant? Are they easily accessible?

- Does your County meet the service needs of its demographic population? If so, how? If not, explain.

- What criteria and/or standards should be developed to measure whether and to what extent, the mental health needs of racial and ethnic minority groups have been met?

- What means of participation in your County's mental health planning process exist for racial and ethnic minorities?

All individuals presenting oral and/or written comments at the hearings should address the above issues. In order to permit all interested individuals appearing before the Committee the opportunity to testify within the allotted time for the hearings, individual testimony will be limited to ten minutes or at the discretion of the Chairperson. Persons not able to be present at the hearings may submit their written comments to the Services to Minorities Committee, Citizens Advisory Council, 714 "P" Street, Room 1592, Sacramento, CA 95814. Written testimony so submitted should be received no later than ten (10) calendar days prior to the scheduled hearing. Copies of the proceeding of the hearings may be obtained from the Office of Advisory Liaison, Department of Health, 714 "P" Street, Sacramento, CA 95814. Cost of the transcripts will be provided to those

requesting, for the same actual and necessary cost of reproduction. Copies should be available no more than three months from the date of the hearing.

Individuals desiring to testify at a specific time due to their schedules should address their request to the Council's Executive Secretary at least ten (10) days prior to the hearing. The request should contain the name of the individual, date and location of hearing, the desired time for presenting testimony, and a summary of the testimony to be presented. Every effort will be made to accomodate such requests.

The Services to Minorities Committee urges all interested individuals, groups and organizations to attend and participate in the hearings. The committee encourages the submission of testimony by monolingual speakers of languages other than English. For this reason, community organizations and others having bilingual capabilities are encouraged to contact the Executive Secretary and make known your willingness to collaborate with us in this effort by volunteering.

Carmen Carrillo Ph.D.

Carmen D. Carrillo, Ph.D.
Chairwoman

Robert L. Jackson
Executive Secretary

cc: Robert Nance, Press Officer
Department of Health

Appendix II

Protocol To Verbal And Written Testimony

Following is the protocol which the Services to Minorities Committee used in its analysis of the verbal and written testimony. Due to time constrictions, only that testimony which pertained to either ethnic or racial minorities were summarized.

Protocol For Transcript Summaries

Use These Headings: (Indicate page number and line number throughout, i.e. p.13, l.27—cite is at page 13, line 27)

1. Name
2. Title (indicate where testifying as an individual not associated with organization)
3. Geographic Area (county, etc.)
4. Ethnic/Race Areas Covered (Mexican American, Native Americans, etc.)
5. Specific Problems/Problem Areas (geographic inaccessibility; lack of bilingual/bicultural professionals, etc.)
6. Specific Recommendations (in-service training; recruitment of personnel, etc. Also indicate if recommendation is specific to particular ethnic/racial group, such as "sweat lodge" for Indians, etc.)
7. Other (add other relevant testimony if any)

*Please specify when statistical information is opinion only (I think the population is...) or based on census reports, department figures, etc. (Opinion is les important here—more important when recommending).

*Important areas are marked in yellow with notations on left page or left side of page—these are not exclusive, however.

*Exclude drug, jail, or children related testimony unless it's specifically related to minorities.

*Pay attention to questions as recommendations.

Appendix III

Summary

Of

Verbal Testimony

Name--RUTHERFORD, Jane Title--Family Services Assoc. of Butte Co. & Glenn Co.

Geo. Area--Glenn & Butte Co. Ethnic/Race--Mexican American

Specific Problems/Problem Areas
1. Lack of bilingual, bicultural counselors (p.122, l.1)
2. Unable to meet needs (p.123, l.10)
3. Minority representation on boards, commissions and committees (p.123, l.20-21)

Recommendations
1. Stronger recruitment of bilingual, bicultural counselors (p.122, l.1)
2. Use local university students (p.122, l.23)
3. Staff training in multicultural aspects of counseling (p.122, l.28)
4. Recruitment out of graduate school (p.128, l.12)

Other
1. Parental stress program (p.120, l.16)
2. Low salaries discourage even minority applicants (p.127, l.20-21)

Name--PONG, Cheryl Title--Minority Advisory Committee Advisory Board, Santa Clara County

Geo. Area--Santa Clara Co. Ethnic/Race--Latino, Native American, Asian Pacific

Specific Problems/Problem Areas
1. Under-utilization of mental health services and programs by ethnic and racial minority populations(p.10,l.22-23)
2. All Short-Doyle agencies incapable of providing services to limited/non-English speaking (p.10,l.24-25)
3. Community workers provided most therapy to limited/non-English speaking(p.11,l.12-15)
4. Lack of bilingual therapists
5. Lack of services to Korean, Indochinese, & Pacific Islander populations (p.12,l.7-10)
6. Culturally and linguistically inappropriate services(p.12,l.22)
7. Lack of outreach (p.12,l.22)

Name--STRONG, Jim Title--Representative on Governing Board of Sub-Area Council of Los Angeles Co. HSA

Geo. Area--West Los Angeles Ethnic/Race--Asians, Latinos

Specific Problems/Problem Areas

1. Not many Spanish speaking services (p.89,1.7). These are characteristically Chicano and many may not be relevant to other Latinos (p.89,1.10).
2. Minimal MH services for aging (p.89,1.14-15)
3. Inaccessible services (p.91,1.5)
4. Problems of non-traditional programs are accreditation, agency referral cooperation and reimbursement(p.92,1.8-11)

Recommendations

1. Culturally relevant and linguistically relevant services for Asian Pacific population (p.88,1.27-28)
2. Community organizer/overall community education(p.89,1.27)
3. Training programs--i.e. Mental Health Training Center(p.90,1.21)
4. Outreach programs(p.90,1.25-26)
5. Follow-up (p.91,1.9)
6. Non-traditional programs (p.91,1.14)
7. Relevant technical assistance provided by appropriate state agencies (p.93,1.19-20)
8. Industrial mental health(p.94,1.10)
9. Care finding mechanisms (p.97,1.11)
10. Attempt to institutionalize successful innovative programs dealing with minorities(p.106,1.18-20)
11. Long range planning regarding minority needs (p.106,1.26)

Other

1. 50% of clientele is made up of people from Mexico and 50% from South America, Cuba, and Central American (p.101,1.14-15).
2. Bilingual/bicultural staff seem to establish better relationships than those that are solely bilingual (p.101,1.21-22)
3. Fewest services are provided for elderly who experience the most cultural shock (p.104,1.13-14).

Name--POTTS, Jim Title--Representing Self

Geo. Area--Oroville Ethnic/Race--Native Americans

Specific Problems/Problem Areas
1. Problem with alcoholism (p.68,1.20)
2. Lack of culturally relevant program and services(p.72,1.21)
3. No minority representation on MHAB (p.76,1.25-27)
4. Committees don't meet service needs of demographic population (p.76,1-2).
5. High rate of suicide among Native Americans (p.81,1.11-12)
6. Population statistics don't list Indians(p.84,1.23)

Recommendations
1. Sweat Lodge (p.69,1.14)
2. Culturally appropriate services (p.70,1.1-2)
3. More Native Americans on staff of programs that are supposed to be for the benefit of Native Americans(p.74,1.3)
4. Services for youth(p.81,1.13-14)
5. Assess mental health needs in jail (p.81,1.20)
6. Federal or state funds should be utilized for direct services instead of being misappropriated in less important factors (p.82,1.7)
7. Alternative mental health providers (p.86,1.9-10)

Other
1. Indian people will not go to mental health clinics because they don't feel they are crazy (p.68,1.23-24).
2. Many Indian people are discouraged from becoming involved due to negative past experiences (p.72,1.9-11).
3. Cut down on minority programs due to Prop 13 (p.72,1.26).
4. Native Americans have difficulty finding programs that relate to them (p.72, 1.16-17).
5. Approx. 185 different tribes in Calif. (est.) (p.77,1.25).
6. Alcohol is too often seen as the solution to the frustrations arising from a sense of not belonging and jail is too often seen as the solution to dealing with alcoholism(p.79,1.4-7).

Name--GALLYOUT, Jeanne

Title--Minority Subcommittee, Yolo Co. Mental Health Advisory Board

Geo. Area--Yolo Co.

Ethnic/Race--Mexican, Native, Black & Asian Americans

Specific Problems/Problem Areas

1. Cultural lack between minorities and mental health services (p.52,l.24-25)
2. Spanish surnamed people are not necessarily bicultural (p.55,l.4-5)
3. MHAB--weak and minimal orientation (p.58,l.4)

Recommendations

1. Outreach
2. MH workers that can relate to all minorities; bicultural workers (p.55,l.22-23)
3. Recruitment of qualified minority clinical psychologists (p.57,l.3-8)
4. A staff member for board who can devote time to investigate footwork (p.60,l.9-11)
5. Training members of board (p.59,l.13)
6. Analysis of bill before it's presented to the board(p.61,l.16)

Other

1. Drug, alcohol abuse, battered wives and child abuse are MH problems that minority families don't see as MH problems(p.53, l.16-18)
2. Outreach in Yolo Co. amounts to lip service. Problems are discussed but no action is taken (p.54,l.6-7)
3. 10,600 Spanish speaking population in Yolo Co. and 5 Spanish speaking personnel; 3 of which are lower level staff workers (p.54,l.23)
4. Level of education deters minority people from serving on MHAB (p.58, l.17-18)
5. 16% minority population in Yolo Co. but services don't reflect this percentage of population (p.62, l.20-21).

Name—RYCHTERA, Sharon Title—Program Coordinator, Glenn Co. Head Start

Geo. Area—Glenn Co. Ethnic/Race—Mexican Americans, Black & Native Americans

Specific Problems/Problem Areas
1. No crisis services for Spanish speaking in Glenn Co. (p.49,l.16)
2. No family or individual counseling (p.49,l.17)
3. No Native American counselor in mental health services(p.50,l.8)
4. No outreach work from MHS to minorities(p.50,l.9-10)
5. No Spanish speaking personnel in hospital(p.50,l.18-19)
6. Community education in MHS needed
7. Geographical inaccessibility in rural areas; lack of transportation(p.50,l.11-13)

Recommendations
1. Adequately trained staff for counseling (p.52,l.2)
2. Spanish speaking staff to work with families of children that attend Head Start (p.51,l.26-27)

Other
1. Census reports on the number of Mexican American population do not reflect the number of illegal aliens (p.49,l.20-21)
2. Mental health facilities are combined with hospital which leads people to believe that if one goes there one must be crazy (p.50,l.14-17).
3. When people must resort to translation the connotation of the whole meaning or problem may become changed in the process (p.51,l.7-9).

Name—REYES, Maria Title—Chicano American Health Assoc. of Santa Clara Co.

Geo. Area—Santa Clara Co. Ethnic/Race—Mexican American

Specific Problems/Problem Areas
1. Lack of public service to minorities (p.4,l.26)
2. Mental Health Department needs to hire more Chicano professionals As of 1977, only 9 are employed (p.7,l.28).
3. Draft does not utilize local graduates-no recruitment(p.8,l.2-3)

Recommendations
1. Community based services (p.8,l.13)
2. Make existing programs service minorities
3. Fund new programs to do it (p.9,l.3-4)

Name--McGUIRE, Jerry Title--Management Director, Butte Co. Mental Health

Recommendations
1. Case finding for geriatric services (p.111,1.13)
2. Case finding, linking and bringing in indigenous staff (p.111,1.23).
3. Bilingual/bicultural staff (p.113,1.22).

Name--VALENZUELA, Leonor Title--Director, Concilio Mexicano

Geo. Area--Butte, Glenn & Tehama Co. Ethnic/Race--Mexican Americans

Specific Problems/Problem Areas
1. Problems in regard to Mental Health stem from low income, unemployment, lack of education(p.35, 1.15-18).
2. No outreach in programs (p.35, 1.23-24). Need of assessment (p.43, 1.11).
3. Under-utilization in Butte is 60%; in Sutter Co. it's 75% (p.36-37, 1.27-1)
4. No development of cultural programs (p.36, 1.5)
5. Inadequate personnel in crisis center; personnel is not bilingual or bicultural, they lack cultural undertanding (p.36,1.14, 16,17).
6. Lack of inservice teaching of any sort to counselors (p.37, 1.1-3).
7. No real preventive care available to Spanish speaking(p.40,1.1-2)

Recommendations
1. Mental health agencies should have programs that are culturally relevant (p.38,1.4-5)
2. Bilingual personnel (p.38,1.6)
3. Better trained personnel (p.39,1.6)
4. Preventive care (p.39,1.28)
5. In-service training of staff in relation to cultural differences among clients (p.41,1.28)
6. Adequate minority representation on Mental Health Advisory Board (p.42,1.22-23)
7. Advisory Committee on minority mental health needs(p.43,1.1)

Other
1. Lack of bicultural personnel leads to misunderstanding values and motives of Spanish speaking people seeking assistance (p.37,1.14-17).

Name--MUNOZ, Mateo Title--Community worker, outreach worker, Butte Co. Legal Serv., Native American Council, MECHA

Geo. Area--Butte Co. Ethnic/Race--Mexican Americans, Native Americans

Specific Problems/Problem Areas
1. Lack of bilingual, bicultural mental health services staff within Butte Co. (p.16, l.12-13).

Recommendations
1. Outreach out of mental health services in Butte Co. (p.12,l.25-26
2. Bilingual, bicultural staff
3. Family and youth counseling (p.19, l.24,27).
4. Bilingual, bicultural personnel to place children in MR classes (p.22,l.2-3).

Name--RYAN, Andrea Title--Outreach Worker, California Human Development Corp.

Geo. Area--Butte Co, Glenn & Tehama Co. Ethnic/Race--Mexican

Specific Problems/Problem Areas
1. Public agencies in area do not provide proper outreach for Spanish speaking community (p.25, l.2-4).
2. Lack of sufficient number of bilingual/ bicultural staff (p.25,l.13-14).
3. No counseling services with Juvenile Hall (p.26,l.9-11).
4. No facilities for mental health patients (p.28,l.13-14).

Recommendations
1. Recruitment of bilingual/bicultural staff to deal with specific problems of Spanish speaking community (p.30,l.26-27).

Name--McGUIRE, Jerry Title--Management Director, Butte Co Mental Health

Geo. Area--Butte Co. Ethnic/Race--Mexican & Native American

Specific Problems/Problem Areas
1. No minority representation on MHAB
2. No outreach recruitment of personnel (p.11,l.10)

Name—SMITH, Ruth Title—Centro de Informacion Medica y Educacion

Specific Recommendations
1. Recruitment of qualified Spanish speaking personnel, particularly in mental counseling (p.8, 1.19).

Other
1. Mexican American families suffering from cultural clash that is threatening the family unit (p.9, 1.2,8).
2. Future serious problems in family pattern of Latin American culture in rural Calif., Nothern Calif. (p.10. 1.9-11).

Name—BUSH, Michael Title—Butte County Legal Services

Geo. Area—Butte Co. Ethnic/Race—Mexican Americans

Specific Problems/Problem Areas
1. Heavy dependence on drug therapy rather than individual therapy of counseling type nature (p.11, 1.7-8).

Recommendations
1. Outreach through Cal. State Univ. at Chico; bilingual, bicultural staff (p.12, 1.13).
2. Individual therapy of counseling nature (p.11, 1.8).

Other
1. Approximately 74% of people who live in Gridley are Spanish speaking (p.13, 1.27-28). Population in Gridley area is approx. 5,000 max. (p.14, 1.25).
2. The majority of Spanish speaking people live in Gridley. Next largest is Chico. Oroville has the bulk of black population (p.15, 1.9-11).

Name—CLARK, Shirley Title—Representing Self

Geo. Area—Butte Co. Ethnic/Race—Native American, Blacks

Specific Problems/Problem Areas
1. Recruitment of mental health counselors (p.44, 1.13-14).

Recommendations
1. Minority people on staff (p.45,1.17-18).
2. Minority slot on advisory board (p.47, 1.19-20).

Name--Theakston, Mary Title--Community Services Coordinator, Butte County Head Start

Geo. Area--Butte Co. Ethnic/Race--Spanish speaking, Mexican Americans

Specific Problems/Problem Areas

1. Ongoing counseling (p.4, 1.9)
2. Spanish speaking counselors in Gridley area particularly (p.4, 1.10-11)
3. Services for children throughout mental health program (p.4, 1.16)where all members of the family could go needs to be available to low income people (p.4,1.20-21)
4. No minority programs nor any satisfactory agreements (p.5, 1.5-6)

Specific Recommendations

1. Recruitment of more Spanish speaking counselors particularly in Gridley area (p.4, 1.14-15, 1.11)
2. Shelter for battered wives/multi-ethnic, in Gridley area (p.7, 1.11, 16)
3. Development of programs to serve Spanish speaking population (p.7, 1.3-4)

Other

1. Some of the Spanish speaking families go to their priests and clergymen to get help, but some of them need ongoing counseling (p.5, 1.14-16).
2. Occasionally, there are counselors who speak Spanish, but these are Anglos and not Mexican Americans who have more knowledge of the culture (p.6, 1.23-26).
3. Problems faced by Spanish speaking Mexican American families seem to be contributing to the break-up of the family unit (p.7, 1.9-10).

Name--SMITH, Ruth Title--Centro de Informacion Medica y Educacion

Geo. Area--Butte Co.,Glenn & Tehama Co. Ethnic/Race--Spanish speaking

Specific Problems/Problem Areas

1. No Spanish speaking persons that are qualified to handle mental health problems in Northern Calif. area(p.8, 1.20-22).
2. No qualified Spanish speaking mental health technicians, clinicians or professional people to handle mental health problems (p.9, 1.14-16).

Name--FONG, Cheryl Title--Minority Advisory Committee, Advice Board

Recommendations
1. Development of resource list for hiring purposes--recruitment (p.13,l.3-4)
2. Evaluation of Santa Clara County Plan in non-compliance with affirmative action, in-service training, adequate cultural and linguistically appropriate programs and services for minorities (p.13,l.15-18)
3. Implementation of necessary programs and services to ethnic and racial minorities (p.14,l.1-2)
4. Culturally and linguistically relevant services to minorities (p.14,l.4)
5. New monies for mental health programs and services (p.14,l.10)
6. Enforcement of mandates and legislation for relevant mental health (p.14,l.15)

Other
1. Some Agencies identified staff personnel as therapy providers although their qualifications were inappropriate(p.11,l.3-4).
2. Santa Clara County-17% Spanish surnamed; 41 therapists (mostly paraprofessionals), 0 Native American therapists, 7.5 Asians.

Name--VILLOLDO,Dr. Title--Multi-cultural psychological health

Geo. Area--Santa Clara Co. Ethnic/Race--Chicanos, Latinos

Specific Problems/Problem Areas
1. Outreach is not culture and language sensitive(p.19,l.3-4)
2. Prevention(p.19,l.21)
3. Stress and hypertension with migrant people(p.20,l.7-8)
4. No safeguards that ethnic minorities will be aware of their legal rights (p.21,l.4-6)
5. Need for training and technical assistance(p.21,l.9)
6. Need of liaison between MH service and community programs (p.21,l.19-20)
7. Paraprofessional training (p.22,l.2-3)
8. Lack of follow-up (p.22,l.22)

Recommendations
1. Care process--14day hold(p.25,l.19)
2. Community education in mental health(p.23,l.2)

Name--WESSON, Kenneth Title--Representative, Association for Black Social Workers

Geo. Area--Santa Clara Co. Ethnic/Race--Blacks

Specific Problems/Problem Areas
1. Lack of preventative mental health programs for Black (p.30,1.6)

Recommendations
1. Increase funds for preventative information and services in mental health (p.30,1.10)
2. Development of comprehensive network for diagnosis, treatment and rehabilitation for Blacks (p.30,1.14)
3. Coordination and collaboration between services (p.30,1.18)
4. Promotion of development of education and information programs for young Blacks(p.30,1.18-19)
5. Establish quality assurance and monitoring programs of services for Blacks (p.30,1.21-22)

Other
1. Planned programs seldom moved beyond planning process into implementation phase (p.27,1.7-8).
2. Lack of mental health education information and services becomes a social community handicap (p.28,1.11-12).

Name--STAPP, Claudia Title--Director, Santa Clara Co. Chapter of M.H.A.

Geo. Area--Santa Clara Co. Ethnic/Race--Mexican American

Specific Problems/Problem Areas
1. Under-utilization of services (p.50,1.21)
2. No programs to serve Spanish speaking in East Valley Mental Health Center (p.53,1.24-25)
3. Mental health centers are grossly out of compliance with intent of federal legislation (p.54,1.21)

Recommendations
1. Cut off funding to institutions with inequitable service delivery (p.57,1.12-13)

Other
1. Raza population is 17.5% according to 1970 Census (p.50,1.8-9).
2. 12.8% of '74-5 mental health caseload came from Spanish speaking community (p.50,1.19).

Name—SMITH, Aaron Title—President, Black Social Workers, San Jose Chapter

Geo. Area—Santa Clara Co. Ethnic/Race—Black

Specific Problems/Problem Areas
1. Lack of programs for mental health needs of Blacks(p.33,1.13)
2. Lack of Black professional staff(p.33,1.16-17)
3. Lack of coordination among mental health services(p.33,1.21)
4. Inadequate, unavailable data (p.34,1.1)
5. Mental health resources are inadequate(p.34,1.6)
6. Lack of culturally sensitive services(p.34,1.8)
7. Lack of adequate needs assessment of Black community(p.34,1.15)
8. Problems and need areas must be identified (p.34,1.15)
9. Lack of funds for services to Blacks (p.33,1.8)

Recommendations
1. Prevention (p.34,1.19)
2. In-service ethnic awareness training (p.34, 1.20)
3. Outreach (p.34, 1.23)
4. Input by community (p.34,1.28)

Other
1. Black population of Santa Clara County has grown from 18;090 in 1970, to 30,000 in 1975 (stat)(p.32,1.14-15).

Name—VIDA, Estella Title—Mexican American Women's Assoc. in San Mateo Co.

Geo. Area—San Mateo Co. Ethnic/Race—Mexican American

Specific Problems/Problem Areas
1. Lack of leadership of administration (p.59,1.24)

Recommendations
1. More ethnic members on administrative level(p.60,1.11-12)

Name--PABLO, Eugene Dr. Title--Pastor, Sojourn of Truth Presbyterian Church

Geo. Area--Contra Costa Co. Ethnic/Race--Blacks

Specific Problems/Problem Areas
1. Geographic inaccessibility (p.41,l.20)
2. Lack of Black professional workers in mental health (p.41,l.26-27

Recommendations
1. Center based community centers(p.41,l.4-5)
2. Crisis intervention and preventive therapy(p.41,l.26-27)
3. More Black personnel (p.41,l.8)
4. Less drug dispensing; more therapeutic work (p.41,l.9)
5. Interested citizens to confront county regarding mental health needs (p.41,l.11-12)
6. On-the-job training (p.42,l.9)
7. Train the paraprofessional staff (p.42,l.11-12)

Other
1. Only one Black on MHAB in Contra Costa (p.48,l.2).
2. MHAB--87% White composition; 13% minority composition(p.49,l.10-2

Name--SILVA, Joseph Title--Servicios Humanos

Geo. Area--Sacramento Ethnic/Race--Mexican American

Specific Problems/Problem Areas
1. Need for comprehensive mental health services (p.61,l.15)
2. Lack of bilingual staff (p.61,l.24)
3. Community education information on programs available(p.63,l.5)
4. Lack of follow-up referrals (p.63,l.3)

Recommendations
1. Day treatment, halfway houses, drug programs, crisis clinics and vocational rehabilitation (p.61,l.19-20)
2. Range of services tailored to meet needs of Chicanos(p.62,l.10)
3. Bilingual/bicultural staff (p.62,l.16)

Name—CIENA, Francis Title—Central East Gardner Clinic

Geo. Area—San Jose Ethnic/Race—Chicano,Latino

Specific Problems/Problem Areas
1. Geographic inaccessibility (p.65,1.1-2)

Recommendations
1. Bilingual staff (p.65,1.6)
2. Community education (p.65,1.7)
3. Research (p.69,1.12)

Other
1. Reciprocal arrangement to need assessments (p.68,1.13).

Name—PORTER, Michele Title—Coordinator, Black Mental Health Outreach Program

Geo. Area—Sonoma Co. Ethnic/Race—Black

Specific Problems/Problem Areas
1. Lack of 3rd world health professionals (p.73,1.26)
2. Inaccessibility of services (p.74,1.15)
3. Services aren't culturally relevant to 3rd world communities (p.74,1.28)

Recommendations
1. Community education on mental health (p.74,1.18)
2. Community base programs staffed with 3rd world professionals (p.75,1.22-23)
3. Emphasis on education and information (p.75,1.26)
4. Undo stigma associated with mental health (p.78,1.4)
5. More community involvement (p.76,1.8)
6. Trained community volunteers (p.76,1.12)
7. Institute relevant health care (p.78,1.16)
8. Funding for minority programs (p.76,1.9)
9. In-service programs (p.77,1.9)

Other
1. Sonoma County—3.5% Black population; 12-15% Chicano and 5-6% Native American.

Name--COCHRAN, Carmen Title--Representative,MHAB, Yolo Co.

Geo. Area--Yolo Co. Ethnic/Race--Mexican American

Specific Problems/Problem Areas
1. Lack of Mexican American staff on MHAB
2. Lack of proper therapy (p.82,l.3)
3. Problems with delivery system (p.82,l.26)

Recommendations
1. Outreach (p.82, l.25)

Name--BECERRA, Estela Title--San Mateo Community Worker, Member of LULAC

Geo. Area--San Mateo Ethnic/Race--Spanish speaking

Specific Problems/Problem Areas
1. Need support and communication from professionals in mental health (p.83,l.17-18)
2. Problems with referral (p.83,l.26)

Recommendations
1. Utilization and augmentation of present programs and work

Other
1. Total San Mateo County population 556,363; largest minority group is Spanish speaking with a total of 95,545 (p.84,l.6-7).

Name--MARTINEZ, Geraldine Title--Intertribal Friendship House

Geo. Area--Bay Area Ethnic/Race--Native American

Specific Problems/Problem Areas
1. Limited services for Indian people (p.97,l.27)

Recommendations
1. No specific recommendation

Name--LACALLE, Jose Dr. Title--Clinical Psychologist, Health Planning Council

Geo. Area--Orange Co. Ethnic/Race--Spanish speaking

Specific Problems/Problem Areas
1. Insufficient services and facilities for Spanish speaking (p.85,1.17)
2. Community mental health is understaffed and unoriented(p.86,1.22)
3. Inadequate staffing (p.87,1.9)
4. Decentralization (p.89,1.10)

Recommendations
1. Change of attitudes in county administration (p.87,1.24)
2. Cultural sensitivity (p.88,1.24)
3. Community based clinic (p.89, 1.16)

Other
1. 13% Spanish speaking or 229,000 people (stat) (p.83,1.27-28).

Name--HANSON, Wynne Title--Coordinator, Native American Social Workers Project of S.F. State University

Geo. Area--Bay Area Ethnic/Race--Native American

Specific Problems/Problem Areas
1. Shortage of Indian mental health workers (p.91,1.17)
2. Ineffective treatment and referral of Indians by non-Indians (p.92,1.3-4)
3. Need money to train mental health workers (p.93,1.2)

Recommendations
1. Community mental health facilities staffed with culturally sensitive Indian therapists (p.91,1.21-22)
2. Programs needed should work with Dept. of Social Services(p.94,1)
3. Residential treatment (p.94,1.10)
4. Vocational rehabilitation and parenting classes for minors (p.94,1.13)
5. Training mental health personnel for Indian social services (p.94,1.19)
6. Outpatient services (p.94,1.21)
7. Urban Indian mental health not be addressed only from reservation Indian viewpoint (p.94,1.24-25)
8. Task force to set up Native American health model for urban areas (p.94,1.26)
9. Monies allocated to fund Native American health centers(p.95,1.4)

Name--CHIN, Rena Title--East Bay Asian Mental Health Coalition

Geo. Area--Alameda Co. Ethnic/Race--Asian

Specific Problems/Problem Areas
1. Lack of translators (p.103, 1.28)
2. Insufficient services

Recommendations
1. Culturally relevant and effective services (p.102,1.20)
2. Direct services (p.105,1.19)
3. Professionally trained personnel(p.105,1.20)
4. Indirect services--training other people (p.105,1.21-22)
5. Acupuncture as demonstration project (p.106,1.23)

Name--KIM, Tom Title--Director, Korean Community Center in San Francisco

Geo. Area--San Francisco Ethnic/Race--Koreans

Specific Problems/Problem Areas
1. No Korean bilingual services in mental health or public service field (p.108,1.12-13)
2. Misleading media image (p.108,1.4-5)

Recommendations
1. No specific recommendation

Other
1. 26-30 thousand Koreans in Bay Area (p.108,1.1-2).
2. 16,000 Koreans in San Francisco (p.198,1.4-5).
3. 90% immigrant population (p.108,1.10).

Name--SHON, Steven Dr. Title--Psychiatrist, Richmond Maxi-Center, Chair, Board of Directors of Korean Service Ctr

Geo. Area--San Francisco Ethnic/Race--Korean

Specific Problems/Problem Areas
1. Difficulty with employment and adapting to Western culture(p.110)
2. Korean children become alienated within school system(p.110,1.17)
3. No Korean bilingual workers in mental health (p.111,1.10)

Recommendations
1. Services staffed by bilingual personnel

Name—DE LA CRUZ, Ed Title—Filipino Mental Health

Geo. Area—Bay Area Ethnic/Race—Filipinos

Specific Problems/Problem Areas
1. Need survey (p.114,1.13)

Recommendations
1. Coordination with mental health agencies in assuring comprehensive assessment and treatment planning (p.114,1.14-25)
2. Need to involve existing community resources (p.114,1.21)
3. Promote education and sensitivity of the staff of mental health agencies (p.113,1.24-25)

Name—NGUYEN, Twan Title—District 5 Mental Health Ctr In San Francisco, Psychologist

Geo. Area—San Francisco Ethnic/Race—Indochinese

Specific Problems/Problem Areas
1. Emotional problems stemming from evacuation(p.117,1.8)
2. Lack of preparation for immigration for refugees (p.117,1.12)
3. Cultural and linguistic barriers (p.117,1.20)
4. Uncertainty about future (p.117,1.22)
5. Unemployment, underemployment, inadequate housing (p.117,1.27-28)
6. Lack of services (p.118,1.12)

Recommendations
1. Funding for mental health services (p.118,1.26)
2. Outreach and strong mental health education (p.119,1.12)
3. Community outreach and organization into services(p.119,1.18)
4. Competent bilingual/bicultural persons (p.119,1.27)

Name—FANGA, Pasa Title—Samoan Community Spokeperson

Geo. Area—Santa Clara Co. Ethnic/Race—Samoan

Specific Problems/Problem Areas
1. Low level of education (p.138,1.7)
2. Language barriers (p.129,1.9)

Recommendations
1. No specific recommendation

Name--LOOS, Pat Title--Office of Samoan Affairs Representative

Geo. Area--Los Angeles, San Diego, Bay Area Ethnic/Race--Samoan

Specific Problems/Problem Areas
1. Lack of services (p.122,l.21-22)
2. Language barrier (p.123,l.10)

Recommendations
1. No specific recommendation

Name--TAE, Matau Title--Samoan Affairs

Geo. Area--Los Angeles, San Diego, Bay Area Ethnic/Race--Samoan

Specific Problems/Problem Areas
1. Problems with employment, education (p.124,l.12)
2. Breakdown of extended family network (p.125,l.15)

Name--Misa Title--Organization of American Samoans in California

Geo. Area--Santa Clara Co. Ethnic/Race--Samoan

Specific Problems/Problem Areas
1. No specific problem discussed

Recommendations
1. Mental health education (p.126,l.20)
2. Training and hiring of Samoan speaking personnel (p.126,l.21)
3. Bilingual education in school (p.126,l.28)
4. In-service training (p.127,l.28)
5. Increase of referral centers (p.127,l.13)

Name—YOKATA, Issei

Title—Japanese Mental Health Caucus Group

Geo. Area—East Bay, Santa Clara Co.

Ethnic/Race—Japanese

Specific Problems/Problem Areas

1. Low rate of utilization (p.129, l.24)
2. Monolingual Japanese elderly (p.130, l.23)
3. Drug abuse among the young (p.130, l.28)
4. Deterioration of Japanese American family (p.131, l.27)
5. No Japanese bilingual cultural services within community services (p.132, l.89)
6. Lack of outreach (p.132, l.13)
7. Lack of consultation/education services (p.132, l.19)
8. No preventive programs or services (p.132, l.21)
9. Lack of representation of Asians on MHAB (p.133, l.20)

Recommendations

1. Bilingual, bicultural providers (p.130, l.8)

Other

1. County plans submitted to State fail to be reviewed (p.135, l.1).

Name—CONTRERAS, Juanita

Title—Mission Mental Health, Latinos for Emerging Bilingual MHS

Geo. Area—San Francisco

Ethnic/Race—Spanish speaking

Specific Problems/Problem Areas

1. Lack of proper representation (p.140, l.21)
2. Lack of funding (p.141, l.22)

Recommendations

1. Bilingual staff to serve non-English speaking in health facility (p.140, l.17)
2. Health training programs for multi-lingual population (p.141, l.14)
3. More responsiveness to community needs by university-run hospitals (p.142, l.23)

Name--SCHIMMEL, Jerry Title--Mental Health Planner, Community Mental Health Services of S.F.

Geo. Area--San Francisco Ethnic/Race--Chinese, Japanese, Homosexual

Specific Problems/Problem Areas
1. Recruitment made only on basis of bilingual factors does not guarantee bicultural personnel (p.146, l.25-26)
2. No language standard set by Civil Service Commission (p.147, l.10)

Recommendations
1. Civil service recruitment (p.146, l.28)
2. Contract mechanisms (p.147, l.3)

Name--GOODE, Jerry Title--Director, Indochinese Settlement and Bicultural Center in Santa Clara Co.

Geo. Area--Santa Clara Co. Ethnic/Race--Vietnamese

Specific Problems/Problem Areas
1. Need bicultural, bilingual paraprofessionals (p.149, l.20-22)

Recommendations
1. Training of paraprofessionals (p.149, l.28)

Name--RIESGO, Elisa Title--Mental Health Educator Consultant, El Centro

Geo. Area--Oakland Ethnic/Race--Raza

Specific Problems/Problem Areas
1. No specific problems discussed

Recommendations
1. Culturally sensitive mental health services (p.153, l.15)
2. Cultural awareness training (p.153, l.21)
3. Increased comprehensive services at preventive or educational level (p.153, l.25-26)
4. Political and cultural consciousness raising (p.154, l.5)

Name--RIESGO, Elisa Title--Mental Health Educator
Centro De Salud Mental

Recommendations
5. Outreach (p.155,1.16)
6. Channel increased monies into mental health for expansion of services and adequate salary levels(p.155,1.24-27)
7. Negotiating contracts to allow implementation and development of culturally relevant mental health services(p.156,1.1-3)
8. Community based programs staffed by culturally knowledgeable and sensitive workers (p.156,1.18-20)

Name--CAMARGO, Frank Title--Centro De Salud Mental

Geo. Area--Oakland Ethnic/Race--Raza

Specific Problems/Problem Areas
1. Resources, funding (p.157,1.21)

Recommendations
1. Culturally sensitive programs that are accessible to people and able to train paraprofessional and set up field placements (p.158,1.3-6)

Name--MITSUMASA, Geri Title--Pacific American Rehabilitation Services

Geo. Area--San Francisco Ethnic/Race--Pacific Asian

Specific Problems/Problem Areas
1. Problems of delivery of services and continuing to identify needs (p.152,1.11)

Recommendations
1. Development of programs to meet needs insuring effective implementation of services (p.152,1.14-15)

Other
1. 1977 reports 1,290,000 Pacific Asians in California or 5.3% of the population (p.151,1.14-15)

Name—PETERSON, Alicia Title—South Bay Guidance Center, Chula Vista

Geo. Area—San Diego Co. Ethnic/Race—Spanish speaking

Specific Problems/Problem Areas
1. Lack of bilingual/bicultural professionals (p.10,1.22)
2. Patients must be seen through interpreters (p.11,1.5)
3. Use of untrained staff to provide therapy (p.11,1.8-9)
4. Disparity in-service offered to middle class English speaking patients versus non-English speaking patients (p.11,1.1)
5. Lack of adequate recruitment of qualified bilingual/bicultural professionals (p.14,1.1)
6. Funds needed for such programs

Recommendations
1. Recruitment, training and educating of staff (p.12,1.3-4)
2. Training of paraprofessionals (p.12,1.25-26)
3. In-service education and training for staff (p.15,1.3)

Name—VARGAS, Manuel Title—Mental Health Specialist, San Ysidro Community Health Ctr

Geo. Area—San Ysidro, San Diego, Imperial Valley Ethnic/Race—none specified

Specific Problems/Problem Areas
1. Disparity between services offered to minorities and other services (p.4.1.16-18)

Recommendations
1. Education on mental health (p.5,1.4-5)
2. Outreach (p.5,1.19)
3. Community advisory groups (p.7,1.16-17)

Other
1. Lack of education on mental health leads to distrust of mental health services (p.8,1.25)

Name—FLORES, Carolina Title—Community Services Mental Health Assistant, San Ysidro Mental Health Dept.

Geo. Area—San Diego Co. Ethnic/Race—Spanish speaking

Specific Problems/Problem Areas
1. Lack of indigenous healer's credentials (p.17,1.2-4)
2. Lack of supportive bicultural professionals (p.18,1.13)
3. Lack of paraprofessional surgeons and bilingual staff in emergency wards (p.18,1.19-20)
4. Lack of bilingual/bicultural professionals (p.19,1.4-5)
5. Community services have low priority (p.22,1.15)

Recommendations
1. Hiring of indigenous healers as consultants (p.17,1.2-3)
2. Cross-cultural staffing (p.18,1.10)
3. Lower requirements for bilingual/bicultural professionals(p.19,1)
4. In-service (p.20,1.20)
5. Services to minorities (p.21,1.3)
6. Supportive programs (p.22,1.10)
7. Referral system (p.25,1.18)

Other
1. Working in conjunction with indigenous healer has been successful (p.16,1.17)
2. Surveys that identify percentage of minorities employed in an institution fail to reveal percentage of minority professionals (p.19,1.1-2)
3. Indigenous healer is a spiritual healer (p.23,1.1-2)
4. Patients come in with stress and anxiety problems, suicide problems, hyperventilation, child abuse, battered wives(p.25,1.11

Name—ODENS, Pete Title—Senior Affairs Program Supervisor

Geo. Area—Imperial Co. Ethnic/Race—All minority senior citizens

Specific Problems/Problem Areas
1. No specific problem discussed

Recommendations
1. No specific recommendation

Other
1. 3 Spanish speaking clubs, 2 Filipino clubs, 2 Black clubs (p.94,1.22-24)

Name--VILLAFLOR, Dulzura

Title--Los Angeles Health Systems Agency

Geo. Area--Los Angeles

Ethnic/Race--Asian/Pacific American, Filipino

Specific Problems/Problem Areas

1. Rapid increase in new Asian and Pacific American immigrants--earlier research projects do not apply to recent immigrant groups (p.28, l.17-20)
2. Asian and Pacific American populations become more heterogeneous (p.29, l.12)
3. Asian and Pacific Americans prefer to use indigenous community workers and caretakers versus professional mental health care--underutilization (p.30, l.2-3)
4. Lack of sufficient data on mental health problems of Asian and Pacific Americans (p.30, l.25)
5. Insufficient training (p.31, l.14)
6. Low number of actually available mental health professionals (p.33, l.3)
7. At risk groups largely unattended (p.33, l.13)
8. Mental health stigma (p.34, l.16)

Recommendations

1. Service delivery, personnel training, research, policy (p.28, l.1-5)
2. Relevant and culturally sensitive resources (p.28, l.12-13)
3. Variety of choices for mental health services (p.29, l.25)
4. Bilingual, bicultural staff (p.30, l.13)
5. Reduce barriers to accessibility and stigma (p.30, l.20)
6. Outreach (p.35, l.7-8)

Other

1. "Condition of Asian and Pacific Americans in Terms of Mental Health."

Name--DIAZ, Marshall

Title--Program Director, El Proyecto Del Barrio

Geo. Area--San Fernando Valley, Los Angeles Co.

Ethnic/Race--Spanish Speaking Americans

Specific Problems/Problem Areas

1. Lack of funds (p.39, l.21)
2. Lack of data regarding percentage of Spanish surnamed who use mental health facilities (p.41, l.9-10)

Name—DIAZ, Marshall Title—Program Coordinator, El Proyecto del Barrio

Specific Problems/Problem Areas
3. Research reveals that no specific agencies deal with immediate mental health needs of Chicano-Mexican community, no depth methodological development with Chicano-Mexican client in mind (p.41-42)
4. High incidence of substance abuse (p.45,1.15)
5. High incidence of child and spouse abuse(p.46,1.1)
6. Lack of bilingual/bicultural mental health professionals(p.46,1.2
7. Inappropriate services (p.46,1.25-26)
8. Under-utilization of mental health facility (p.47,1.2)

Recommendations
1. Bicultural/bilingual mental health services and counselors (p.40,1.6-9)
2. Child and family services (p.43,1.4)
3. Culturally relevant services (p.48,1.5-6)
4. Funding of programs (p.48,1.14)
5. Training (p.48,1.10)
6. Information on agencies providing services (p.52,1.16)

Other
1. Low level of education attainment, high poverty level, high unemployment, high crime rate (p.42,1.12-16)

Name—ALVAREZ, Francisco Title—Doctor

Geo. Area—Imperial Co. Ethnic/Race—Mexican American, Filipino

Specific Problems/Problem Areas
1. Lack of education materials in Spanish (p.99,1.25)
2. Need to identify people who need help (p.101,1.7)
3. No programs for psychiatric nursing (p.101,1.7)
4. Great deal of need in Filipino community (p.102,1.21)
5. Problems of education of Mexican Americans (p.102,1.26)
6. Lack of bilingual staff at El Centro Community Hospital(p.104,1.
7. Lack of facility and staff in mental health for Mexican Americans (p.198,1.5-6)

Recommendations
1. Outreach (p.108,1.16-19)

Name--PARADA, Ramon Title--Imperial Co. Community Mental Health

Geo. Area--Imperial Co. Ethnic/Race--Mexican American

Specific Problems/Problem Areas
1. Problems in identifying needs--family dysfunction, youth, broken homes, drug addiction and alcoholism (p.62,l.15)
2. Lack of funding (p.65, l.18)
3. Need consumer input for needs of community (p.66-67)
4. Few mental health services for inmates (p.69,l.4-5)

Recommendations
1. Bilingual/bicultural mental health professional staff(p.64,l.12)
2. Female mental health staff, battered wives (p.64,l.18)
3. Administration at decision making level (p.64,l.26)
4. Programs and services to meet needs of community (p.67,l.15-16)
5. Need consumer input for needs of community (p.66-67)

Other
1. 60% of population is Mexican American in Imperial Co.
2. 35% of population is under 25 years old(p.65,l.10-11)

Name--CORTEZ, Carpenter Title--Assistant Chief Probation Officer

Geo. Area--Imperial Co. Ethnic/Race--Indian, youth

Specific Problems/Problem Areas
1. Need for outpatient care for young (p.72,l.14)
2. Drug and alcohol abuse
3. Lack of bilingual/bicultural therapists (p.73, l.26)
4. Lack of professional correctional staff (p.74,l.19)

Recommendations
1. Emergency crisis intervention (p.74,l.22)
2. MHAB awareness and responsiveness (p.76,l.9)

Other
1. 1 1/2 psychiatrists in county mental health (p.74,l.2)
2. Only one community based program (p.75,l.14).

Name—MADONNA, Bill Title—Business Manager, Imperial Valley Mental Health Services

Geo. Area—Imperial Co. Ethnic/Race—Mexican American

Specific Problems/Problem Areas
1. Unsuccessful recruitment of bilingual, bicultural therapists (p.77, l.14)
2. Black community not reached (p.84, l.8)
3. Unable to assign psychiatric worker to specific locations (p.86, l.1-2)
4. Discontinuance of mobile emergency van (p.89, l.20)
5. Approximately 9000 Mexican Americans in need of services (p.90, l.14-15)

Recommendations
1. Focus on community services (p.93, l.2)

Other
1. 3 Mexican American staff in Calexico (p.78, l.9)
2. Average of 30 visits per month at Calexico. Total visits 500 (p.81, l.10-15)
3. In April, 46% of services went to Mexican Americans (p.81, l.15); 45% utilization in 60% population (p.82, l.15)
4. 75-85% of minority clientele in day treatment center (p.83, l.6).

Name—SHINN, James Title—Imperial Valley Community Mental Health

Geo. Area—Imperial Co. Ethnic/Race—Mexican American

Specific Problems/Problem Areas
1. Lack of bilingual, bicultural staff in administration (p.110, l.24-25)
2. Problems in accessibility and transportation (p.111, 17)
3. Lack of effective recruitment of bilingual, bicultural psychiatrists (p.110, l.24)
4. Need for advocacy program (p.112, l.3)
5. Need for consumer input (p.113, l.20)
6. Senior citizens and mentally disabled, young not being reached (p.114, l.18-19)
7. People are not informed about available services or staff (p.115, l.18)
8. Lack of informed individuals in planning services (p.116, l.5)

Name—SHINN, James Title—Imperial Valley Community Mental Health

Recommendations
1. Quality control (p.114, l.8)

Other
1. Questionnaires—results on needs and meeting of needs.

Name—KATSIGEANIS, Dr. [illegible] Amalia Title—Imperial Valley Methadone Clinic

Geo. Area—Calexico, Imperial Co. Ethnic/Race—Mexican Americans

Specific Problems/Problem Areas
1. Lack of culturally relevant drug treatment (p.119, l.11)
2. Alcoholism, lack of bilingual mental health staff (p.121, l.17)

Recommendations
1. Detox program and methadone maintenance program in Calexico (p.120, l.23-25)

Name—PITTMAN, Marnie Title—Community Service Worker

Geo. Area—Imperial Co. Ethnic/Race—Mexican Americans

Specific Problems/Problem Areas
1. Lack of outreach to overcome superstition (p.124, l.15-16)
2. Apathy (p.126, l.5)

Recommendations
1. Education materials (p.125, l.7)
2. Staff input (p.125, l.21)

Name—NAVA, Alex Title—Community Services

Geo. Area—Imperial Co. Ethnic/Race—Mexican Americans

Specific Problems/Problem Areas
1. Lack of bilingual staff (p.126, l.24)

Recommendations
1. Mental health literature in Spanish (p.128, l.17)

Name—AGUIRRE, Manual E. Title—Social Worker, Representing Self

Geo. Area—Tulare Co. Ethnic/Race—Spanish surnamed

Specific Problems/Problem Areas
1. Language barriers (p.6, l.7)
2. Lack of professional minority staff (p.6, l.9)
3. Sporadic recruitment of Chicano/Mexican staff (p.6,l.9)
4. Lack of facilities for acutely disturbed mentally disabled minority people (p.6,l.19-21)
5. Lack of professional staff to work with emotionally disturbed minority people (p.6,l.22-24)
6. Lack of culturally relevant services (p.6,l.26)

Recommendations
1. Relevant and easily accessible programs for minorities (p.7,l.7)
2. Recruitment of minority staff using competitive salaries and additional incentives (p.8,l.7-8)
3. Programs for mentally disordered sex offenders (p.11,l.12).
4. Programs for the Spanish speaking elderly (p.12,l.25-26)

Other
1. Large group of offenders (one third) are minorities, Spanish speaking (p.11,l.6).

Name--MACIAS, Jose Title--Representing Self

Geo. Area--Fresno Co. Ethnic/Race--Chicanos

Specific Problems/Problem Areas
1. Shortage of Chicano mental health professionals (p.15,1.4)
2. Lack of culturally relevant mental health services (p.16,1.18)
3. Need for research--assess mental health services needs for minorities (p.17,1.11-12)
4. Under-utilization of mental health services by minorities (p.18, 1.4)

Recommendations
1. Increase in bilingual/bicultural professional staff (p.20,1.12)
2. Recruitment at early stages of educational level (p.23,1.16-22)

Other
1. Only three Chicano professionals employed in East Outreach Program (p.15,1.14)
2. No Chicano professionals in West Outreach Program (p.16,1.29)
3. Six Chicano MSW in Fresno Co. Mental Health Program (p.16,1.13)
4. Undocumented aliens constantly fearing arrest (p.21,1.7)

Name--SALAZAR, Cipriano Title--Project Director, Fresno Federacion Rural de Salud de California

Geo. Area--Fresno Co. Ethnic/Race--Chicano

Specific Problems/Problem Areas
1. Geographic inaccessibility of services (p.63,1.7)
2. Problems with hard core drugs and alcoholism (p.66,1.3,12)

Recommendations
1. Staff that can communicate with people that are being served (p.61,1.18)
2. Need for tie-in between educational system and service system (p.61,1.26-27)
3. Training of paraprofessionals (p.63,1.3)
4. Funds for rural areas (p.63, 1.26)

Name--RISCO, Eliezer Title--Director, Planning & Development with United Health Ctrs.

Geo. Area--Fresno & Tulare Ethnic/Race--none specified

Specific Problems/Problem Areas
1. Shortage of Chicano bilingual/bicultural professionals in mental health (p.27,l.2)
2. Lack of bilingual/bicultural curriculum development (p.27,l.15-16)
3. Need for clear policy formation and program development (p.28,l.18-19)
4. Need for direct services practitioners (p.36,l.16)
5. Need for considering inter-county agreements to deliver comprehensive services to minority communities (p.39,l.3)
6. Problems with accessibility (p.45,l.6)

Recommendations
1. Recruitment at JC levels
2. Development of joint powers, inter-county contacts when assessing needs (p.31,l.18)

Name--CORMIER, Larry Title--Fresno Community Member

Geo. Area--Fresno Co. Ethnic/Race--Black

Specific Problems/Problem Areas
1. Drug problems and ineffective programs (p.68,l.7)
2. No Blacks in decision making positions (p.71,l.25)
3. High turn over of Black staff (p.75, l.15)

Recommendations
1. Explore innovative and more effective programs to deal with drug problems (p.68,l.11-12)
2. Early drug intervention by minority counselors (p.78,l.22-23)

Name--SANKS, Barbara Title--Association of Black Social Workers

Geo. Area--Fresno Co. Ethnic/Race--Black

Specific Problems/Problem Areas
1. Misdiagnosing due to effects of the system on Black individual (p.52,1.9)
2. Lack of alcoholism programs (p.55, 1.18)

Recommendations
1. Public relations education on mental health (p.47,1.10)
2. Mental health become available as consultative segment in service centers (p.47,1.25)
3. Coordination of service centers with social services(p.48,1.11)
4. Comprehensive mental health centers in Black community (p.49,1.3)
5. Services must be accessible (p.49,1.10)
6. Funds allocated for continuing in-service training for staff (p.50,1.56)
7. Intensive training dealing with Blacks in health system(p.50,1.56
8. Recruitment of Black professionals (p.56,1.5)
9. Vertical mobility for paraprofessionals (p.56,1.7)

Name--STODOLA, Adelle Title--Mental Health Planning Analyst, Kern County Mental Health Development

Geo. Area--Kern Co. Ethnic/Race--Black, Spanish speaking

Specific Problems/Problem Areas
1. Lack of Black professional staff (p.80,1.4)

Recommendations
1. National core people: training of minorities (p.80,1.22)
2. Education of public on mental health (p.84,1.24)

Other
1. 26% minorities in Kern County (1977 Census Report) (p.79,1.25)

Name--YOON, Frank Title--San Francisco Northern Calif. Pacific Asian Coalition

Geo. Area--San Francisco Ethnic/Race--Pacific Asian American

Specific Problems/Problem Areas
1. Lack of minority professional staff (p.86,1.23)
2. Lack of culturally relevant programs (p.87,1.2)
3. Programs are inaccessible (p.87,1.7)
4. Lack of appropriate standards (p.87,1.24)

Recommendations
1. Affirmative Action on Advisory Boards (p.88,1.27)
2. Hiring of bicultural staff (p.88,1.28)
3. Recruitment of graduate students (p.89,1.2)

Name--DUCKETT, Rhoda Title--Society of Calif. Care Home Operators, SOCCO

Geo. Area--San Francisco, Richmond, Los Angeles Ethnic/Race--Minority mentally disabled

Specific Problems/Problem Areas
1. Lack of bicultural/bilingual staff (p.94,1.17-18)

Recommendations
1. No specific recommendation given

Other
1. 40% of residents of state hospitals are minority people (p.95,1.2)

Name--SOSA, Luis Robert Title--Social Worker, Trabajadores de la Raza

Geo. Area--Fresno Ethnic/Race--Chicano

Specific Problems/Problem Areas
1. Lack of minority professional staff in drug abuse and mental health (p.98,1.6-7)
2. Lack of centralized services (p.98,1.15)
3. Lack of information provided to Chicanos (p.98,1.25-26)
4. No multi-treatment programs (p.99,1.12)
5. No client advocacy and development nor community development program (p.101,1.9-11)

Appendix IV

Summary

Of

Written Testimony

Name--EMORY, Margaret Title--East Bay Creative Living Center Coordinating Council

Geo. Area--Alameda Co. Ethnic/Race--Varied

Specific Problems/Problem Areas
1. Dis-orientation of clients due to language barriers
2. Lack of bilingual/bicultural services

Recommendations
1. Provide bilingual services
2. Contract existing community mental health program to provide services to population described in Specific Problems #1
3. Recognize the need for bilingual/bicultural services in the planning of mental health services

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Name--COSTA, Manuel J. Title--Association of Short-Doyle Contract Agencies

Geo. Area--Santa Clara Co. Ethnic/Race--no particular group

Specific Problems/Problem Areas
1. Lack of bilingual/bicultural services

Recommendations
1. Develop a central pool of resources on a county-wide basis
2. Employ staff sensitive to the population's needs, uniqueness
3. Use community people and groups as sources of manpower, expertise and decision-making, regarding programs and priorities

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Name--MARTINEZ, Carlos, M.D. Title--Alviso Family Health Center

Geo. Area--Santa Clara Co. Ethnic/Race--Spanish speaking persons

Specific Problems/Problem Areas
1. Great need for health services
2. Inadequate and/or non-relevant providers and facilities
3. Insufficient and/or maldistribution of funds
4. Inadequate health education for the Spanish speaking
5. Need for recruitment, hiring and educational opportunities for increasing the number of bilingual/bicultural health professional
6. Low priority of mental health services in general but also in particular for the Spanish speaking communities

Name—MURASE, Kenji Dr.

Title—Pacific/Asian Coalition

Geo. Area—California

Ethnic/Race—Cambodian, Chinese, East Indian, Guamanian, Hawaiian, Japanese, Korean, Pilipino, Somoan, Thai, and other Asian and Pacific Island ethnic communities

Specific Problems/Problem Areas

1. Under-utilization of mental health services by group
2. Lack of bilingual/bicultural services

Recommendations

1. Re-definition of mental health service
2. Training and hiring bilingual/bicultural staff
3. Long-range planning and commitment to developing and maintaining such programs
4. Changing present legislation to one that would allow culturally relevant services rendered to population
5. Integrating services outside of the catchment area in order to service those who are widely dispersed
6. Increased support for research and demonstration directed to the development of treatment modalities that are culturally relevant to population served
7. Existing support system be consulted, involved and supported in mental health services
8. Expansion of preventative/outreach programs
9. Recognition of the diversity and differences among ethnic group and therefore recognizing their differing resources and needs

Other

1. According to the 1970 Census there were 539,000 (less than 3% of the population in California) Chinese, Japanese, Koreans & Pilipinos
2. An estimate for the total Asian & Pacific Island population in California is 1,350,000 or slightly more than 5% in 1977

Name--ATIENZA, Rebecca Title--Asian Community Mental Health Services

Geo. Area--East Bay Ethnic/Race--Pilipino

Specific Problems/Problem Areas
1. Lack of intensive, extensive, expanded preventative mental health programs (culturally relevant)
2. Lack of social service agencies' sensitivity and responsiveness to needs of immigrants
3. Lack of Pilipino bilingual/bicultural mental health staff and therapists

Recommendations
1. Community based preventative mental health and therapeutic services
2. Training and skills development for employees
3. Bilingual/bicultural staff in social service agencies
4. Opportunities for further training for Pilipino therapists trained abroad

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Name--CHEN, Serena Title--East Bay Asian Mental Health Coalition

Geo. Area--East Bay Ethnic/Race--Chinese & Asian groups

Specific Problems/Problem Areas
1. Under-utilization of mental health facilities by Chinese due to insufficient bilingual/bicultural programs
2. Lack of outreach and educational programs

Recommendations
1. Outreach facility staffed with bilingual/bicultural professionals and paraprofessionals that is community based and community controlled
2. Develop a half-way house to serve as an alternative to institutionalization
3. Develop a Day Treatment program which provides activities
4. A 24-hour emergency service
5. Clinical services to children, youth, and seniors
6. Community education
7. Consultation
8. Advocacy, Changing of legislation to recognize culturally relevant services
9. Chinese/Asian representation on State Boards/Commissions

Name--KIM, Tom Title--Bay Area Coalition of Koreans/ Korean Community Service Center

Geo. Area--Bay Area Ethnic/Race--Koreans

Specific Problems/Problem Areas
1. Lack of bilingual/bicultural services
2. Lack of bilingual staff in social services agencies

Recommendations
1. Provide bilingual/bicultural services
2. Have the federal government support local programs that are dealing with immigrant mental health needs
3. Change the concept of catchment areas in order to include those which are dispersed

Other
1. There are over 28,000 Koreans (est. given in 1975)
2. 90% of the Korean population residing in America are recent immigrants

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Name--FARLOUGH, Eugene Title--Pastor, Sojourner Truth Presbyterian Church

Geo. Area--Richmond Ethnic/Race--Blacks

Specific Problems/Problem Areas
1. Lack of centers in the black communities
2. Lack of Crises Intervention, psycho-cultural, family-oriented center
3. Lack of Black staff in the present agencies/centers
4. Less drug dispensing and more counseling
5. Lack of culturally relevant services

Recommendations
1. Develop a Crises Intervention, psycho-cultural, family-oriented center
2. Base #1 in the black community's greatest areas of mental health needs
3. Staff be predominantely black
4. Staff be able to relate to the black clientele
5. Staff be trained and qualified in dispensing drugs
6. On-the-job training and programs to upgrade para-professionals's skills

Name--No specific individual Title--Office of Samoan Affairs, Inc.

Geo. Area--California Ethnic/Race--Samoan/Pacific Islanders

Specific Problems/Problem Areas
1. Lack of bilingual/bicultural staff
2. Inadequate administrative, financial and communicative systems
3. Under-service to Samoan/Pacific Islanders

Recommendations
1. Increase bilingual/bicultural staff at all levels
2. Give priority in hiring Samon/Pacific Islanders
3. Recruit and increase the number of Samoans/Pacific Islanders for graduate training
4. Develop outreach programs culturally relevant to Samonas given by Samoans also living in the community
5. Provide financial support for above recommendations

Other
1. In the state of California there are 89,100 Pacific Islanders/ Samoans (1977, HEW Initiative)

Name--No specific individual Title--The Pilipino Mental Health Resource Group

Geo. Area--Bay Area Ethnic/Race--Pilipino

Specific Problems/Problem Areas
1. A general lack of insensitivitiness to the Pilipino culture by present agencies
2. Lack of bilingual/bicultural workers (especially in key positions

Recommendations
1. Increase participation of the patients' family and other support systems
2. Involve existing community resources
3. Increase the number of bilingual/bicultural Pilipino workers

Other
1. There are approximately 100,000 Pilipinos in the Bay Area

Name--No specific individual Title--Chicano Mental Health Assoc.

Geo. Area--Santa Clara Co. Ethnic/Race--Raza/Chicano

Specific Problems/Problem Areas

1. Lack of bilingual staff
2. Lack of utilization resources allocation to meet the Spanish speaking's needs
3. Lack of planning to meet the needs of the Spanish speaking (culturally and linguistically relevant)

Recommendations

1. Increase the number of Chicano staff in all positions
2. Ongoing documentations regarding the adequacy of services provided to the Chicano community
3. Have the county accept non-traditional and alternative mental health methods
4. Contact Chicano professionals and culturally oriented programs
5. Funds be allocated in accordance with the parcentage of the population served
6. Culturally relevant services be provided
7. Allow the community to have input as to the center's goals, objectives, and to allow the community to monitor and evaluate mechanisms
8. Account for all Chicano related mental health services
9. Hold all funds until services reflect this document's intent
10. Indigenous categories of illness be recognized and indigenous treatment modalities be used
11. Encompass community practitioners with the needs of the community
12. Outreach programs be used
13. Making home visits
14. Cultural sensitivity training for mental health therapists and providers at all levels
15. Develop an intensive outreach program
16. Develop a liaison with community agencies (all types)

Other

1. According to the 1970 Census, Chicanos comprised 17.52% of the total county population
2. Santa Clara County Mental Health Services Plan (FY 1977-1978) show that 12.3% of the total cases were Spanish-surname individuals

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Name--SHIMADA, Leland Title--Asian Community Mental Health Services

Geo. Area--Alameda Co. Ethnic/Race--Asian Americans

Specific Problems/Problem Areas

1. Preventative programs that are culturally relevant and meeting the needs of the community
2. Lack of sensitivity and response to the community's needs by the social service agencies (employment, housing, job training, transportation)
3. Lack of bilingual/bicultural staff and therapists
4. Lack of support services and groups that could aid in communicating as well as understanding family members and/or agencies
5. Lack of programs that could help recent immigrants deal with the culture shock
6. Bilingual/bicultural social workers are low in numbers where the Asian clientele is relatively high
7. Lack of centers that are physically accessible and culturally relevant
8. Lack of community education about mental health
9. Lack of home visits on a regualr basis
10. Lack of combined outpatient, outreach services
11. Lack of representation to boards and legislative bodies

Recommendations

1. Solicit and provide for more Asian representation to policy and evaluation boards, commissions, and committees
2. Establish a permanent Ethnic Minorities Mental Health Board at the state level
3. Provide culturally relevant services at sites located in the community
4. Provision for contractual services/consultation by practioners of traditional Asian methods of treatment
5. Have a bilingual/bicultural community oriented staff
6. Develop an intensive and extensive outreach/preventative program
7. Provide education programs for the entire family and community
8. Recognize the significance of the extended family structure and indigenous support systems as well as the present support systems
9. Revise the catchment area concept in order to provide services to those who are dispersed
10. Provide more short-term, crisis-oriented services

Other

1. Alameda County has the 3rd larges Asian/Pacific Islander population in California.

Name—TOM, Jane Chang Title—Ethnic Minority Concerns Committee

Geo. Area—Alameda Co. Ethnic/Race—no specific group

Specific Problems/Problem Areas
1. No specific problem discussed

Recommendations
1. Increase caseloads of ethnic groups under-utilizing services
2. Secure trained/experienced mental health professionals
3. Provide bilingual/bicultural services by bilingual/bicultural staff
4. Develop method for assessing needs of ethnic minorities
5. Insure participation of the minority groups in assessing the needs of their respective communities
6. Complete needs assessment for each ethnic group significantly represented in the population to be served
7. Conduct research to assess the positive and negative impact and the effectiveness of services provided

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Name—QUAN, David Title—Chinese Mental Health Task Force

Geo. Area—San Francisco Co. Ethnic/Race—Chinese

Specific Problems/Problem Areas
1. Under-utilization of services
2. Catchment areas needs to be redefined in order to serve those who are dispersed
3. Lack of bilingual/bicultural staff

Recommendations
1. Have bilingual/bicultural staff
2. Continued funding of NEMHC programs serving Chinese
3. Provide bilingual emergency services
4. Provide bilingual/bicultural in-patient and out-patient services
5. Provide aftercare services

Other
1. There are 68,596 Chinese (10.3%) in San Francisco (1970 Census)
2. Of the clients of San Francisco's Community Mental Health Services only 2% were Asians (estimation).

Name—PONG, Cheryl Title—Minority Advisory Committee Santa Clara MHAB

Geo. Area—Santa Clara Co. Ethnic/Race—no specific group

Specific Problems/Problem Areas
1. Under-utilization of mental health services by minorities
2. Lack of bilingual/bicultural providers
3. Inadequate in-service training

Recommendations
1. Immediate implementation of necessary programs and services to minorities
2. Provide bilingual/bicultural services
3. Utilization of existing resources by the counties to implement needed services to minorities rather than depending upon augmentation and other funding sources
4. New monies for mental health programs and services
5. Need for enforcement of mandates and legislation for relevant mental health services to minorities

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Name—Organization's statement Title—Organization of American Samoa

Geo. Area—Santa Clara Co. Ethnic/Race—Samoans

Specific Problems/Problem Areas
1. Lack of bilingual/bicultural staff
2. No Educational and outreach program
3. Lack of identification of resources and programs
4. Lack of cultural sensitivity by present social agencies

Recommendations
1. Mental health education
2. Training and hiring Samoan speaking workers
3. Early identification of mentally deficient cases and proper medical assistance
4. Identification of services, resources and facilities where assistance can be obtained
5. Cultural awareness workshops for the staff of social services agencies, public health department, and public school systems
6. Development of a referral center to coordinate efforts related to mental health needs of the Samoan community

Name--LIM, Marion and Jerry Lee

Title--AACI Asian Pacific Mental Health Program

Recommendations
1. Bilingual/bicultural staff
2. Services need to be community based and directed
3. Utilization of indigenous community support systems
4. Flexible hours and accessibility during the weekends
5. Develop a community education and outreach program
6. Conduct home visits

Other
1. 1970 Census states that there're 5.5% or 85,000 Asian Pacific Islanders in the Santa Clara County.

Name--Nguyen, Tuan, Ph.D.

Title--representing self

Geo. Area--San Francisco, Bay Area

Ethnic/Race--Indochinese (Vietnamese)

Specific Problems / Problem Areas
1. Lack of programs that deal with the cultural shock
2. Lack of bilingual/bicultural staff
3. Lack of present providers that are aware and sensitive to the Indochinese specific background
4. High unemployment and underemployment rate among the refugees

Recommendations
1. Funds be provided to assure the refugees adequate and culturally relevant services
2. Funding mechanisms should be channeled to community coalition or council
3. Develop an outreach and educational program
4. Bilingual/bicultural staff
5. Have a long range planning and commitment to the development and maintenance of programs that provide continuous services

Other
1. Estimation shows that in the Bay Area there are between 20,000 - 25,000 refugees
2. Estimation shows that in San Francisco there are about 12,000 refugees

Name—GOODE, James Title—Indochinese Resettlement and Cultural Center

Geo. Area—Santa Clara Co. Ethnic/Race—Indochinese (Vietnamese)

Specific Problems/Problem Areas
1. Lack of Vietnamese staff and therapists
2. Lack of centers sensitive to the Vietnamese's needs and cultural background
3. Lack of programs that deal with the culture shock and language barriers

Recommendations
1. Bilingual/bicultural staff and therapists
2. Job training and educational opportunities for the Vietnamese
3. Develop programs that directly deal with the cultural changes

Other
1. There are between 8,000 - 10,000 Vietnamese in Santa Clara County (estimation).

Name—LIM, Marion and Jerry Lee Title—AACI Asian Pacific Mental Health Program

Geo. Area—Santa Clara Co. Ethnic/Race—Asian Pacific

Specific Problems/Problem Areas
1. Most of the providers aren't adequately trained and sensitive to the cultural dynamics and issues of the Asian/Pacific Islander population
2. Communities aren't informed about mental health issues and illness as well as not knowing the existence or availability of the centers.
3. Inadequate research methods and data collection processes in assessing the communities' needs
4. Lack of information and referral services to the community
5. Under-utilization of existing services by the community
6. Services aren't culturally relevant to the community
7. Lack of bilingual/bicultural staff
8. A percentage of monolingual Asian/Pacific Islanders' needs not being met due to language barriers
9. Recent immigrants' cultural shock is not dealt with

Appendix V

Correspondence

CITIZENS ADVISORY COUNCIL

Established under Community Health Services Law

714 P Street
Sacramento, California 95814
(916) 445-2090

CHAIRPERSON
Carmen Carrillo, Ph.D.

VICE-CHAIRPERSONS
Armando Morales, D.S.W.
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Larry J. Thompson
Administration, Private Hospital
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County Supervisor
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Committee Appointees
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County Supervisor
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SPEAKER OF ASSEMBLY
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Sociology
Ernest W. Klatte, M.D.
Conference of Local Mental Health Directors
Lila Berman
General Public

EXECUTIVE SECRETARY
Robert L. Jackson

RECORDING SECRETARY
Joanne Starke

January 6, 1978

Dear

The myriad and complex problems in the delivery of mental health services to minorities in the State of California climaxed during the last quarter of 1977 with acute personnel problems at Metropolitan and Napa State Hospitals. Mental health has thus become a focus of attention by Governor E. G. Brown.

The week of December 12-16, 1977, I participated in Governor Brown's Task Force on Mental Health, convened to design a package for mental health services for the State of California.

As chairperson of the Citizens Advisory Council and the Council's Services to Minorities Committee I formulated and presented a 6.6 million dollar package earmarked for programs for services to minorities. The package which is enclosed, consists of a network of services including casefinders, outpatient clinics, half-way houses, and an implementation/evaluation component with prioritization of programs for areas in which minority populations are underserved.

The package may well be lost in cuts that will take place as the total $170-90 million dollar total package is analyzed and priorities are set.

I urge you to write your legislator(s) in support of special monies for services to minorities, to inform them of the crucial need to begin to serve these underserved populations. Please send a copy of your letter to the Governor, and to myself at the address below.

Sincerely,

Carmen Carrillo, Ph.D.
Chairperson
2728 Durant Ave.
Berkeley, CA 94704

CC/mjt
enclosure

SERVICES TO MINORITIES

California enjoys a minority population of 9,536,600, 37.8% of the total state population of 25,201,600*. Mental health statistics place the percentage of persons needing services at 15% of a given population; thus, fully 1,430,490 of California's minority population is in need of mental health services at any one time. However, service delivery to California's minority population is tragically remiss, non-existent in many cases and minimal in most other instances. Affirmative Action and Equal Opportunity have not yet become by-words in the state mental health delivery system as it now stands.

We believe that the lack of services to minorities in this state is so endemic to minorities in this state that only a culturally congruent program can remedy the existing situation and initiate the incorporation of minorities into the mental health delivery system.

The program herein described in comprehensive and modest in scope: it includes case finding and referral, transitional half-way houses, and out-patient services.

* Population figures from: Third World Population in California, Intern Research Project Council on Inter-Group Relation Office of the Lieutenant Governor Sacramento, California 95814

Short-Term Goal: Prevent underservice of minority populations in the state by creating a network of case finders. Twenty (20) Bachelor's level case finders would be funded for areas in which minority services are available. One (1) case finder to be assigned per 45,000 people. Places that would serve as sources for clients would be church groups, day care centers, parent groups, and community health clinics.

Long-Term Goal: To ensure that minority persons who can most benefit from a long-term live-in situation with a full fupport system, or out-patient psychotherapy can be identified and referred to appropriate mental health services.

Year 1:	20 Case Finders @ $ 13,500	=	$ 270,000
Year 2:	20 Case Finders @ $ 14,200	=	284,000
Year 3:	20 Case Finders @ $ 14,900	=	298,000
TOTAL			$ 852,000

Short-Term Goals: Establish minority half way houses in the Southern, Central, and Northern parts of the state to serve the Latino/Chicano, Black, Asian and Native American communities to be found in those three areas of the state. Priority to be North, Central and South Counties with large underserved minority populations.

Long-Term Goal: Effect re-entry of clients into mainstream society and community life.

Year I:	8 Houses @	$120,000	=	$ 960,000
Year II:	8 Houses @	$132,000	=	1,056,000
Year III:	8 Houses @	$146,000	=	1,168,000
Total				$ 3,184,000

Short-Term Goal: Provide mental health treatment on an out-patient basis for minority patients who are currently not receiving services, and who would benefit from culturally appropriate programs. Priority to be North, Central and Southern counties with large, underserved minority populations.

Long-Term Goal: Stabilize patients with dual objectives of promoting and preventing further deterioration.

Year I:	6 Centers at	$ 200,000	= $ 1,200,000
Year II:	6 Centers at	$ 220,000	= 1,320,000
Year III:	6 Centers at	$ 242,000	= 1,452,000
TOTAL			$ 3,972,000

IV. Administration

The Administrative Structure will consist of a Director and three (3) Regional Associate Directors. Main function will be program development and evaluation.

Year I:	$ 130,000
Year II:	136,500
Year III:	143,500
Total	$ 410,000

THREE YEAR BUDGET

		1978-79	1979-80	1980-81	TOTAL
I.	Case Finders	$ 270,000	$ 284,000	$ 298,000	$ 852,000
II.	Half-way Houses	960,000	1,056,000	1,168,000	3,184,000
III.	Outpatient Facilities	1,200,000	1,320,000	1,452,000	3,972,000
IV.	Administration	130,000	136,500	143,500	410,000
	GROSS BUDGET	$2,560,000	$2,796,500	$3,061,500	$8,418,000
	SAVINGS	(50%)(1,280,000)	(20%) (559,300)	(0%) -0-	(1,829,300)
	ADJUSTED BUDGET	$1,280,000	$2,237,300	$3,061,500	$6,578,700

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STATE OF CALIFORNIA — EDMUND G. BROWN JR., Governor

CITIZENS ADVISORY COUNCIL

Established under Community Health Services Law

714 P Street
Sacramento, California 95814
(916) 445-2090

CHAIRPERSON
Carmen Carrillo, Ph.D.

VICE-CHAIRPERSON
Armando Morales, D.S.W.
Noel E. Maxwell, M.D.

Members
Governor Appointees
Robert Lofthus-Williams, M.D.
General Medicine
David Pfingst, M.D.
General Psychiatry
Noel Hernandez Maxwell, M.D.
Child Psychiatry
Carmen Carrillo, Ph.D.
Psychology
Armando Morales, D.S.W.
Social Work
Ruth Ann Terry, R.N.
Nursing
Larry J. Thompson
Administrator, Private Hospital
Donald M. Hillman
County Supervisor
Paula Starr Sloyd
General Public

CHAIRMAN, SENATE RULES
Committee Appointees
Michael Eddy
Law
County Supervisor
James A. Harris
General Public

SPEAKER OF ASSEMBLY
Appointees
Mamie Harman, Ph.D.
Sociology
Bruce W. Klatte, M.D.
Conference of Local Mental Health Directors
Lila Sorman
General Public

EXECUTIVE SECRETARY
Robert L. Jackson

RECORDING SECRETARY
Jeanne Starks

Honorable Edmund G. Brown, Jr.
Governor
State Capitol Bldg.
Sacramento, Ca. 95814

Dear Governor Brown:

The purpose of this letter is to express my personal disappointment concerning the allocation of monies for services to minorities in your budget for programs to overhaul the State's mental health system. Tremendous work and energy were spent by myself with the assistance of other interested minority individuals in the formulation of the original request for 10 million dollars presented to you as part of the Mental Health Task Force report in December, 1977.

As you know, the quality and quantity of mental health services available to California's ethnic/racial minorities is deplorable. Since I organized the minority services committee of the CAC, we have heard consistent reports of inadequate funding, inaccessible and non-existent services throughout the state. During the course of the last two public hearings on minority mental health services which the Minority Services Committee of the CAC has held, these reports have been documented repeatedly. On behalf of the CAC I proposed that the 10 million dollars requested would begin to make a dent in such inequitable conditions.

The cutbacks affecting services to minorities are particularly disheartening since the request was made with the consensus of the Mental Health Task Force and the agreement of the Department of Health.

I trust you will not be surprised if the minority communities object to what once again seems to be insensitivity on the part of a bureaucracy that relies on minority support, yet forgets the needs of these communities when funding is under consideration.

Sincerely,

Carmen Carrillo, Ph.D., Chair

CC:yf

STATE OF CALIFORNIA — EDMUND G. BROWN JR., Governor

CITIZENS ADVISORY COUNCIL

Established under Community Health Services Law

714 P Street
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Nursing
Lucy A. Thompson
Administrator, Private Hospital
Donald M. Hillman
County Supervisor
Paula Hoff Sewell
General Public

CHAIRMAN, SENATE RULES
Committee Appointees
Maxwell Eddy
Law
County Supervisor
Jeffrey A. Haven
General Public

SPEAKER OF ASSEMBLY
Appointees
Marvin Harmon, Ph.D.
Psychology
Ernest W. Klatte, M.D.
Conference of Local Mental Health Directors
Lee Lehman
General Public

EXECUTIVE SECRETARY
Robert L. Jackson

RECORDING SECRETARY
Jeanne Starks

February 22, 1978

Mr. Carl Rauser
Chief
Mental Health Program
744 P Street
Sacramento, CA 95814

Dear Mr. Rauser:

Thank you for your letter of January 30th. I have given careful consideration to the contents of your letter and within this context respond as follows.

As you know, the Citizens Advisory Council has placed a high priority over the next few years on mental health services to minorities. In order to assess the services and program needs of minorities, the Council is proposing to hold four public hearings throughout the state this Spring. The purpose of these hearings is to determine minority needs based on a sound data base as permitted by the current state of the art. The findings of need will be transmitted to the Department for their consideration and appropriate action.

Presently, what appears to be lacking is a set of criteria and standards by which proposals, submitted by the Counties, can be judged to ascertain whether or not the proposed programs, if implemented, will in fact meet a true need. It is the development of such standards and criteria that the Council wishes to address itself. The Council firmly believes that the responsibility of developing these standards should rest with the Department of Health. The Department has at its disposal the necessary resources to undertake such a task. Since consultants are available to you, the Council requests your consideration of the following proposed action.

-1. Department of Health, with input from the Council and other outside individuals and groups, develop draft criteria and standards to be used in assessing proposal to meet mental health needs of minorities.

-2. Draft criteria developed by the Department is then presented to the Services to Minorities Committee of the Council for consideration in public meetings to provide for broad public input.

-3. Services to Minorities Committee recommends to the full Council the adoption of the criteria and standards.

-4. Full Council recommends to the Department of Health the adoption and utilization of the criteria and standards in its review and funding of proposals for services to minorities.

In addition, the Department could use the information contained in the Mental Health Report submitted to the Governor on services to minorities as background material in developing the criteria and standards.

The material not only addresses the underserved areas of minority populations, but funding levels as well. This information can certainly be used by local and state agencies as a guide in their planning, developing, implementing, and evaluation of a comprehensive description of model minority services.

The Citizens Advisory Council stands ready as the states volunteer advisory group on mental health, to work in harmony with the Department to develop needed services to our minority populations.

Your consideration of our request is appreciated.

Sincerely,

Carmen D. Carrillo, Ph.D.
Chairwoman

CDC/lls
cc: Members, CAC
Robert Jackson

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Appendix VI

Memoranda From The Department Of Health To Local Mental Health Directors And Program Chiefs Regarding Services To Minorities And Standards For Advisory Boards

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714 P STREET
SACRAMENTO, CALIFORNIA 95814

November 3, 1977

To: Local Mental Health Directors and
Program Chiefs

Subject: Mental Health Services to Minorities

Attached for your information and use are copies of The Department of Health "Policy and Intent Statement Regarding Mental Health Services to Minorities," and the proposed regulations on "Standards for Advisory Boards, Committees, and Subcommittees for Local Mental Health Services."

Both of these documents were unanimously adopted as amended by the California Conference of Local Mental Health Directors, on October 7, 1977, in the full conference meeting at Yosemite National Park, California.

Sincerely,

Albert Seltzer

Al Seltzer
Executive Secretary
California Conference of
Local Mental Health Directors

"UNANIMOUSLY ADOPTED AS AMENDED BY THE
CALIFORNIA CONFERENCE OF LOCAL MENTAL HEALTH DIRECTORS
OCTOBER 7, 1977"

POLICY AND INTENT STATEMENT REGARDING MENTAL HEALTH SERVICES TO MINORITIES

INTRODUCTION

Overall goals of the State's mental health program are to: (1) reduce the incidence of severe mental disability; (2) reduce dependence on institutionalization; (3) increase access for all Californians to appropriate direct mental health services; and (4) ensure a full range of well-integrated mental health services providing continuity of care.

It is recognized by the Department, local government, numerous private and public agencies, organizations, groups, and individuals that accessibility to mental health resources is especially limited for certain populations isolated by geographic, social, cultural, and political factors.

The purpose of the "Policy and Intent Statement Regarding Mental Health Services to Minorities" proposed by the Department of Health is to ensure that appropriate mental health services and programs are planned, developed, implemented, maintained, and evaluated to meet the mental health needs of minorities in a fiscally responsible manner.

To achieve this purpose, the Department, working in harmony with the county mental health programs and other concerned groups, has developed the following policy to be addressed by the counties in the development and implementation of their mental health plans, programs, and services. The following items would apply to regular Short-Doyle programs:

I. DATA COLLECTION

Each county shall utilize in the county plan information provided by the Department of Health on the county population by race, ethnic group, sex, age, physical and mental disability, income, and primary language in which each person is fluent, if that person is not fluent in English. Any racial/ethnic group listed below may be deleted and another substituted in its place if the listed racial/ethnic group does not represent a significant portion in need of service of the total county population and the substituted racial/ethnic group represents a significant portion in need of service of the total county population and is more appropriately included in the data collection effort. The Department shall waive the reporting requirements for any county in which it is agreed by the Department and the county that there is not a significant number of any of the groups listed below.

C. Language by Sex and Age — percent primary language as defined in I other than English of county population; monolingual as well as bilingual:

1. Spanish

2. Chinese

3. Filipino

4. American Indian

5. Other — specify

Each county shall provide the following data:

D. For each minority group listed in IA and B above, each county shall provide data in the plan on each group regarding the percent and total number of discharges from all county mental health programs for the preceding year.

E. Provider Staffing Patterns

Each county shall provide data in the plan regarding county or contract mental health staff by race, ethnic group, sex, program, employment position, and region employed.

This data shall be expressed in full-time equivalents. The bilingual/bicultural capabilities of staff shall also be reported.

F. Each county shall list the presently existing programs which are specifically designed to meet the mental health needs of the county's minority populations.

II. MINORITY NEEDS ASSESSMENT AND AFFIRMATIVE ACTION

A. Minority Needs

Each county shall compare minority utilization rates of each mental health program to utilization rates of the nonminority population and distinguish between voluntary and involuntary programs. The county shall also estimate special characteristics of minority populations which would indicate a need for increased or different services. In reporting this data, counties should note undercounting of minorities by U. S. Census where appropriate.

"UNANIMOUSLY ADOPTED AS AMENDED BY THE
CALIFORNIA CONFERENCE OF LOCAL MENTAL HEALTH DIRECTORS
OCTOBER 7, 1977"

STANDARDS FOR ADVISORY BOARDS, COMMITTEES, AND SUBCOMMITTEES FOR LOCAL MENTAL HEALTH SERVICES

Title 9, California Administrative Code,
Chapter 3, (NEW) Subchapter 3

Article

1. County Mental Health Advisory Boards

2. Committee on Minority Mental Health

3. Advisory Committee to County Mental Health Advisory Boards

4. Waiver

Article I. County Mental Health Advisory Boards

1340. Composition. (a) The composition of the Mental Health Advisory Board shall reflect the minority populations found in the county.

(b) Each county shall indicate in the County Mental Health Plan the total number of current board members and their minority group affiliation, if any.

(c) Each county shall describe in the plan efforts being made to place presently unrepresented and underrepresented minority group members on the Advisory Board, including a timetable to achieve equitable representation.

(d) Each county shall reimburse Mental Health Advisory Board members and Committee members for reasonable expenses incurred as a result of participation in Advisory Board and Committee duties, when such expenses present an obstacle to participation by any member. Reasonable expenses shall include, but not be limited to meals, travel, and child care.

1341. Committee on Minority Mental Health. (a) Each county shall create a committee on minority mental health needs. The committee shall be a subcommittee of the Mental Health Advisory Board. The composition of the committee shall reflect the various minority groups found in the county. The committee shall:

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814

PH: (916) 920 6712

September 8, 1978

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS

SUBJECT: SERVICES TO UNDERSERVED POPULATIONS -- DMH 78-9

This is just a brief reminder that services to minorities and other underserved populations remain a top priority, to be addressed as you consider necessary for post-Proposition 13 revisions to your mental health plan and budgets

To the extent practical, this should include an effort to incorporate worthy 314(d) projects into your plans.

Dale H. Farabee

Dale H. Farabee, M.D.
Director
Department of Mental Health

cc: Mario G. Obledo, Secretary
Health and Welfare Agency

Appendix VII

Guidelines For CMHC

Services To Minorities

Memorandum

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
National Institute of Mental Health

TO : All Community Mental Health Centers DATE: FEB 15 1978

FROM : Steven S. Sharfstein, M.D.

SUBJECT : Guidelines for CMHC Services to Minorities

Through the efforts of the DMHSP Minority Advisory Group, the attached "Guidelines for CMHC Services to Minorities" were developed to reinforce the Division of Mental Health Services Program's support of the intent of Public Law 95-83; specifically, its sections which deal with minority communities. This legislation clearly indicates that the Community Mental Health Centers Program must be made available, accessible to and effective for all Americans through special efforts in the areas of specific CMHC programming and staffing patterns relative to serving minority clients.

The attached guidelines have been developed to address the broad deficiencies in representation of, and services to, minority groups as indicated in review of site visit reports, annual biometry data and recommendations from the current Central Office Two Percent Technical Assistance Project through the Center for Minority Group Mental Health Programs. The content and intent of the guidelines were designed to encompass both the Community Mental Health Centers Act and Title VI of the Civil Rights Act. Their use can be twofold—both as a tool in compliance and monitoring and as an educational resource to sensitize center staff, consumers and citizens to the program and service needs of minority populations.

We feel that the guidelines reflect a mandate of P.L. 95-83. Their release will eventually parallel the availability of technical assistance funds necessary to aid programs and community mental health centers which need assistance in addressing the identified issues.

Your support and commitment to addressing this critical area remains a challenge and concern to staff dedicated to improving the delivery of mental health services to all Americans alike.

FEB 2 1 1978

GUIDELINES FOR CMHC SERVICES TO MINORITIES

P.L. 95-83

December 1977

National Institute of Mental Health
Division of Mental Health Service Programs

GUIDELINES FOR CMHC SERVICES TO MINORITIES

Introduction

An underlying theme of the Community Mental Health Centers (CMHC) Program has always been to ensure the availability of mental health services to all residents of the catchment area. In addition, special efforts have been made to reach underserved portions of the population through outreach and other means. Further, research has demonstrated that minorities are a high risk population. Accordingly, it is necessary to identify those areas of the law with special relevance to the mental health needs of minorities and to provide guidelines for the development and delivery of services to such populations.

Services

Community mental health centers service programs and treatment modalities should at a minimum be planned and implemented in such fashion as to ensure an accessible, equitable and appropriate response to the unique life experiences of minority catchment area residents.

The CMHC should implement programs, policies, and procedures which will assure that all board members and staff will give specific attention to the identification and elimination of practices which impede the delivery of effective and equitable services to minorities. Examples of procedures and practices which should be examined and modified as indicated include: staff behavior at intake; criteria used to determine which staff are assigned to work with minorities; referral determinations; diagnostic procedures, including the use of culturally biased tests; and treatment modalities.

Continued attention to these practices is needed to assure that the management of the CMHC is not contributing to such well documented problems experienced by minorities as low utilization rates, inappropriate diagnoses and treatment modalities, and disproportionately high dropout rates.

The presence of these problems often indicates that staff and board members are not adequately informed about the life experiences and cultures of minorities and may be insensitive to the impact of staff behavior upon minority clients or catchment area residents.

Staff should become aware of and be sensitive to the unique life experiences and cultures of many minority clients which are related to lifestyles developed from the clients' experiences with racism. The minority client's psychological attitude toward the CMHC and its staff may include distrust and inhibitions to being genuinely self disclosing. Board and staff members should be aware that this is likely to have a profound impact upon the development of rapport and to adversely affect therapeutic relationships with minority clients. Appropriate responses to this situation will require sustained attention to the manner in which services are planned and provided.

An appropriate response to these issues should include at a minimum: the implementation of a wide array of flexible and accessible services; multi-racial, bilingual,* and bi-cultural staff, and extensive outreach programs which have been designed with the active involvement of minority catchment area leaders and minority staff.

Program Evaluation

Data and evaluation systems should include provision for effective assessment of the CMHC's plan for meeting the unique needs of minority catchment area residents. The systems should address such issues as: referral source trends, intake and diagnostic patterns, duration of services/treatment, staff characteristics in relation to persons served (i.e., discipline, training, race, knowledge of language, culture and value system, dropout rates, client satisfaction). Such systems should also address changes in the attitudes, behavior, or social conditions of minority individuals; the extent to which minority clients located throughout the catchment area are being served; the nature of program services in relation to minority participation rates and the extent to which all CMHC activities are servicing minorities. Through attention to such issues, more effective planning and program modification can take place.

Relevant and factual data can emerge through the effective use of a variety of existing mechanisms including, but not limited to, the Mental Health Demographic Profile System (NIMH, Division of Biometry and Epidemiology) which has been supplied to States with provisions to share data with centers and the annual program evaluation report required of centers.

Governing Body

The National Institute of Mental Health Governance guidelines state in part that the governing board "must take into account demographic characteristics such as race and ethnic background."

The governing/advisory body should at a minimum be representative of a center's catchment area race and ethnic population composition.

This should assure that minority segments of the community have been involved in the planning, development, monitoring and evaluation of mental health programs affecting their community. Periodic reviews should be undertaken to examine and review the pattern of membership on the board. If an underrepresentation exists, board recruitment patterns should be undertaken to encourage active participation by minority groups including developing methods of orientation and training for interested representatives.

*See "Bilingual Staff" on page four for additional discussion.

Staffing Patterns and Training

In order to assure equal access and delivery of services to minority clientele, the staff of a center should, at a minimum, include minority personnel at all organizational levels (e.g. administrative, supervisory, clinical and support staff levels) reflecting the minority population in the catchment area. All staff should possess at a minimum training and orientation adequate to permit a sensitivity to minorities. If deficiencies exist, intensive, special efforts should be undertaken to recruit, train, and retrain staff capable of addressing minority needs.

Attention should be focused on addressing these issues:

(a) training for individuals in initial public contact positions, e.g., receptionists, volunteers, telephone operators, and clinicians within all service delivery and administrative support components;

(b) assessing existing clinical service delivery techniques, professional staffing and training to assure and, if necessary, modify approaches consonant with minority needs. Particular attention should be paid to the perceptions of minority individuals; perceptions which are often at variance with those of middle-class mental health professionals;

(c) examining recruitment and training efforts which provide the resources for adequate, responsive, and representative staffing patterns. This could address the image of the CMHC within minority communities and institutions, administrative and clinical policy provisions, entry requirements, advancement opportunities, accessibility, availability, appropriateness and acceptability of services;

(d) the establishment of linkages with institutions of higher learning with large segments of a student body of minorities. Efforts directed toward the collaborative development of such programs to address minority mental health needs should be encouraged. Such programs should reflect community needs and should train professionals to address these unique human and social needs;

(e) the development and implementation of an affirmative action plan which specifies the center's intent and methods for eliminating barriers to employment and advancement on the basis of race, creed, gender, age, and prior history of disability.

A formalized program should exist which permits an augmentation of knowledge, understanding and skills as are applicable to minorities within respective communities. This program should be available to the full range of CMHC participants including, but not restricted to,

board members, professionals (clinical and administrative), support staff, initial contact persons, outreach representatives and affiliations, volunteers, and any other individuals with authority and policy-making responsibilities. An effective medium would exist through the use of a program of on-going in-services continuing education with program content focussed on a broad scoped educational training process which addresses staffing patterns, board representation, service delivery techniques, management priorities, patterns of communication, evaluation techniques, etc.

Financial Barriers

All persons in a catchment area, regardless of ability to pay, must be able to seek and receive services. Special efforts should be made to reach minorities who lack financial access to mental health care. These efforts should address the full range of financial barriers to care including those involving fees for services, transportation costs, and loss of employment time.

Bilingual Staff

Section 206(c)(7)(D) of the CMHC Act requires that where a CMHC serves a population including a substantial portion of individuals of limited English speaking ability, the center must develop a plan for meeting the needs of those individuals in an appropriate language and cultural context and must, additionally, identify an individual on its staff who is fluent in the language of the limited English speaking population.

The intent of these provisions is to ensure that all people, regardless of their capacity to communicate in English, will have access to adequate mental health services. The term "substantial" noted in the law is in effect if a population constitutes more than five percent of or more than 3,500 persons in the catchment area (c.f. 42 CFR, section 54.302(k), Federal Register, November 2, 1976). However when any individual of limited English speaking ability is in need of services, it is the responsibility of the CMHC to address such need. In addition, special efforts should be made to link with appropriate community agencies that serve non-English speaking individuals. Through such linkages access to the CMHC can be increased and effective case finding can be enhanced.

As a part of the Federal monitoring process, special attention will be paid to the extent to which CMHCs are serving minorities in general and non-English speaking individuals in particular.

Indian Reservations

Applicants for community mental health center grants whose catchment areas include Indian reservations should secure the participation of the respective Tribal Council or its Health Board in planning for services to residents of the reservation.

Appendix VIII

California's

Department of Mental Health

COMPLAINT PROCEDURE

There are numerous methods for bringing a complaint when a person or group has been discriminated against in the provision of mental health services. It is not always necessary to obtain an attorney to bring a lawsuit. The California Department of Mental Health has recently developed a Civil Rights Plan in accordance with several federal and state non-discrimination provisions (Title VI of the 1964 Civil Rights Act; Rehabilitation Act of 1973, Section 503 and 504 and California Government Code Section 11135). The Civil Rights Plan seeks to assure the equality of delivery of services in the California Mental Health system. The Plan provides for the following complaint procedure:

Complaints Procedure

Any person who feels he/she has been discriminated against in the provision or delivery of mental health services, by any program or activity directly under the Department of Mental Health, or under contract or other arrangement with the Mental Health Department, may file a complaint with the Civil Rights Office of the Department of Mental Health, or

with the Office for Civil Rights at DHEW within 180 days of the alleged act of discrimination.

Form of Complaint to the Civil Rights Office

Written Complaints:

It should contain a description of the exact nature of the occurrence in which the alleged discrimination took place, including:

1. Date, time, and place of the alleged discrimination.
2. Persons involved and circumstances related to the incident.
3. The signature, address, and telephone number of the complainant.
4. The names, addresses, and telephone numbers of any witnesses to the incident.

Oral Complaints:

In the event an oral complaint is received, the staff member receiving it, will advise the complainant on how to formalize his/her complaint in writing, or the staff member will prepare

a written summary of the complaint, including the above required information, which must be acknowledged as accurate and signed by the complainant.

Confidential Complaints:

If a recipient, potential recipient, or participant does not wish to have his/her name used as the person submitting the complaint, the person to whom the complaint is made shall refer the complainant to the Director of Health or the Civil Rights Officer.

Group Complaint:

A group may file a complaint on behalf of a person or group of persons where prior approval is provided by such person or group of persons.

Investigation of Complaint:

Upon receipt of a complaint, the Director of Mental Health or his/her designated representative, the Civil Rights Officer

or others, will investigate the facts and circumstances involved in the alleged violation. In no case will an employee be assigned to investigate a complaint against his/her, or against any employee working under his/her immediate supervision. Procedure for investigation will include:

1. An interview with the complainant.
2. An interview with the official or employee alleged to have acted in a discriminatory manner.
3. A review of the issues involved in the complaint.
4. An investigation of the program, or facility in which the discrimination is alleged to have taken place in terms of the treatment of recipients.

Answer to Complaint:

Within 45 days after receipt of a complaint, the Director of Mental Health of his/her appointed representative, the Civil Rights Officer shall inform the complainant in writing of the outcome of the investigation, and the basis for whatever findings are made. The complainant shall also be informed of his/her rights to a formal hearing and appeal, pursuant to California Government Code Section 11135.

Correction of Discrimination:

If upon investigation of a complaint, discrimination is found to exist either by intention or effect, the Director or his/her delegee, the Civil Rights Officer shall order such discrimination to cease and such steps as are necessary to assure compliance.

Confidentiality of Information:

The identity of any complainant, and the employee or official alleged to have discriminated; and, any information obtained as the result of an investigation are to be confidential, except to the extent necessary to carry out the complaint procedure or any hearing or judicial proceeding arising thereunder.

On-Going Review Of Practices To Assure Compliance

By Program Administrators:

Each program director or administrator of an organization or facility receiving federal or state funds, directly or

through contract or other arrangement with the Mental Health Department, has the responsibility of on-going review of his/her unit's total health services delivery practices, to assure compliance with the spirit and intent of the law, regulations, and the Department's Civil Rights Plan.

Such review shall include analysis of racial and ethnic characteristics of the population to be served; the number of non-English speaking recipients or potential recipients; plans for outreach to substantial minority groups to inform them of the service; plans for providing bilingual services if they are needed; the availability of public or other transportation to the service; and, the hours and days of service in terms of their possible discriminatory effect on the basis or race, color or national origin, age, sex physical or mental disability.

Civil Rights Officer

The Civil Rights Officer shall:

1. Be responsible for a reporting system for the use of programs and agencies receiving federal and state

funds, and review such reports.

2. Analyze programs to verify compliance through:
   a. Surveys
   b. Spot checks
   c. Field investigation
3. Establish linkages with the community to secure the input and participation of disabled, women, minority members regarding mental health service delivery practices, which may result in discrimination.

Corrective Action:

In the event that a program, agency or facility receiving federal and/or state funds, directly or through contract or other arrangement, is found upon review not to comply with the federal or state law and regulations, or the Department's Civil Rights Plan, the Director will require that organization to take corrective action. Such action will include provision wherever possible to any individual or individuals of the benefits, care or services of which he/she was deprived because of a discriminatory practice, and a plan for assuring that discriminatory practices will not re-occur.

Sanctions:

If a program, organization or contractor fails to comply after due-notice and hearing, the Director of Mental Health may suspend, terminate, or refuse to continue state or state monitored federal financial assistance; refuse to grant certification, or initiate license revocation proceedings, or utilize any other means authorized by law to assure compliance, including referral to the State Attorney General's Office with a recommendation that appropriate proceedings be brought to enforce any rights of the State.

Appendix IX

Position Paper Presented To

Alameda County By

The Mental Health Advisory Board

At the Request of

The Ethnic Minority Concerns Committee

The Alameda County Mental Health Advisory Board

This Position Statement was

Prepared and Submitted to

Suzanne Mandel, Ph.D., Director

Alameda County Mental Health Services

May, 1978

The Right of Culture: A Declaration for the Provision of Culturally Sensitive Mental Health Services

THE RIGHT OF CULTURE: A DECLARATION FOR THE PROVISION OF CULTURALLY SENSITIVE MENTAL HEALTH SERVICES AND THE ISSUE OF PROTECTED STATUS

Prepared by:

Wade W. Nobles, Ph. D.
May, 1978

The recognition of culture as a requisite ingredient in the provision of mental health services, requires that one reassess both the notion of culture and the process by which it's expression is guaranteed in this mental health system. Given the cultural diversity of Alameda County, it is even more critical that this reassessment be accomplished. A people's culture, in simple terms, is basically the expression of all that constitutes their every day way of life. More specifically, a people's culture is or includes the vast structures of language, behavior, customs, knowledge, symbols, ideas, and values which provide the people with a general design for living and patterns for interpreting reality. The cultural consciousness of a people represent the shared, symbolic, systematic and cumulative ideas, beliefs and knowledge of their historical, material, and spiritual processes. Because the cultural consciousness of a people and the values consistent with it particularly determine or help to define, select, create and re-create what is considered "real", normal, valuable, desirable, appropriate, etc. (and conversely, what is unreal, abnormal, undesirable, inappropriate, etc.) in the people's social milieu, it becomes and is a necessary variable in the formula of mental health services.

Human societies have always been characterized by a richness of cultural types. Unfortunately, however, the natural cultural diversity associated with human societies has been the subject of a dangerous trend toward standardization wherein all cultural diversity is reduced to a single type or pattern. In the world community, the industrialized "Western Pattern" has been decreed as the standard type. In this country and subsequently, Alameda County, the white or Anglo-American type has been similarly decreed as the standard. The standard type or pattern does, of course, filter through, every aspect of life and, subsequently finds itself being the benchmark for "normality" and therefore, the goal of mental health care. It is not surprising that the mental

health system, like all institutions in this society, can be justifiably indicted as being designed to meet only the needs of middle-class educated white Americans. The issue of this declaration is not, however, to explicate the fundamental basis of American institutions.

The purpose of this declaration is to establish in principle and in practice a people's "right of culture" and the implication this inalienable right has for the provision of mental health services. Since a people's culture represents and encompasses their shared, symbolic, systematic, and cumulative ideas, beliefs and knowledge, and, since mental health concerns by definition must be concerned with its "clients'" ideas, beliefs, etc., about reality, culture must be or should be viewed as the foundation to any "understanding" of mental wellness and/or illness.

In recognizing that because Alameda County has a diverse ethnic minority population, it subsequently has the richness of multiple sets of shared, symbolic and cumulative ideas, beliefs and knowledge, all of which help to provide several definitions of mental wellness, the Alameda County Mental Health System must support the right of each cultural theme to express itself in the provision of mental health services. Hence, the most compelling aspect of this declaration is the recognition of the necessity for culturally sensitive mental health services.

In this light it is important to highlight that the specialness of the diverse cultures necessitates special or unique services and that a true understanding of the cultural specialness is harbored in the people indigenous to a particular culture. Consequently, the presence of indigenous members of

a culture is the necessary (though not sufficient) condition for guaranteeing the integrity of that culture in the mental health network's programs. Similarly, it is important to highlight here that it is recognized that associated with any need to guarantee a particular existence requires the establishment of special practices and/or considerations. Guaranteed job security through a seniority system should be immediately recognized as a special practice designed to guarantee the existence of a particular class (i.e., longevity in service). In fact the underlying rationale for a seniority system, as well as other special practices and/or considerations (e.g., military exemptions, wildlife preserves, etc.) is the principle of "protected status". The practice in law of this principle of protected status is generally associated with an attempt to compensate for some historically defined disadvantage (e.g., 10-point military preference), or in order to protect those class of subjects who would face serious disadvantage, danger and/or harm as a result of unfavorable changes in their environment (e.g., endangered species). The principle of protected status is good, necessary and sound.

The attack on the wide-spread disease of racism in this society has required several special practices, the implementation of affirmative action policies and/or programs being only one. The task of affirmative action programs, in fact, has been to attempt to correct the historical inequity brought about by over a century of special priviledge and advantage for whites and punishment and disadvantage for blacks and other minorities. Affirmative action in fact, if not intent, was designed as one method of rectifying the historical disadvantages associated with racism in this society.

Like the seniority system, affirmative action policies/programs are special practices designed to guarantee a particular existence. Unlike the seniority system, affirmative action is not based on the principle of protected status, it only addresses the issue of compensation for an historically defined disadvantage. It does not as formulated recognize the necessity of securing the "rectification of inequality" by securing as "special status" programs and/or personnel defined as relevant to minority mental health services; and, who otherwise would become victims of the "last hired first fired" policy which is unfortunately not prevented by the seniority system. As such, it cannot alone guarantee the right of culture in the provision of mental health services.

It is now widely recognized that unemployment and mental illness are strongly associated. We who are concerned about the mental illness of our community can not therefore avoid examining the effects of changes in the employment market and in the provision of human services as a consequence of Jarvis/Gann. Without question, the passage of Jarvis/Gann will cause significant changes in the employment opportunities and therefore financial security of minority populations in Alameda County. Blacks and other minorities, particularly Spanish speaking/Spanish surname and Asians, have historically been either completely discriminated against in the employment market or where employed have experienced the racially based insecurity of being the "last hired and the first fired". Passage of Jarvis/Gann will seriously aggravate this social phenomena as well as have a predictable compound effect on the mental wellness of Black and other minority communities.. Predictably Jarvis/Gann will eliminate many of the programs designed to alleviate the mental strains brought about by undo societal stress. The predictable layoffs also associated with Jarvis/Gann's passage will simply intensify the societal strain while simultaneously eliminating those programs designed to

address the very issues which the bill will create. Hence the compound effect of Jarvis/Gann will put minority communities in general, and the minority mental health programs and employees particularly, in the tenuous position of "facing serious dangers to their mental wellness as a result of the predictable unfavorable changes in the environment". The recognition of this alone defines the minority community and its mental health programs and personal as unduly threatened by the passage of Jarvis/Gann.

On both the grounds of historical compensation and threatened existence, this declaration notes that the condition of the programs created and/or designed to meet the mental health needs of minority peoples in Alameda County, as well as minority employees within the system, fully qualify for and should have applied the principle of protected status.

RECLAMATION OF CULTURE AND THE PROVISION OF SERVICES TO CULTURALLY DIVERSE POPULATIONS: A PLAN OF ACTION FOR THE PROVISION OF CULTURALLY SENSITIVE MENTAL HEALTH SERVICES

(1) Active promotion of cultural integrity must be accepted in principle and in policy as an important component in both the provision and development of genuine culturally sensitive mental health services. This attitude necessarily implies the respect for cultural diversity in the definition and treatment of mental illness.

(2) Development plans and/or re-allocation strategies should be reassessed to assure that destruction of the system's culturally sensitive programs for ethnic minority groups is minimized and that excessive sacrifices of the programs and/or personnel which harbor these cultural values are not imposed on this system in the name of efficiency or the necessities of "re-allocation".

(3) Identification of the cultural requisites related to the definition and treatment of mental illness will be formulated by representatives of the diverse ethnic minority groups in ways which build on their own value dynamism so as to satisfy the basic treatment needs and enhance the mental wellness and quality of life of these populations.

(4) Careful, sustained and culturally sensitive research needs to be conducted on how the wider mental health system as a value-bearing, treatment, educational and information system acts as an agent of cultural transformation. A parallel issue in this regard is the recognition that as a cultural agent (oppression), the wider mental health system may be a causal factor in the degeneration of ethnic minority mental wellness.

(5) Support should be given to developing networks within the mental health system to collect evidence and/or data on the harm experienced by different cultural groups by utilizing wider domineering defintions of mental health and subsequent treatment modalities.

(6) Many ethnic communities are presently struggling to establish culturally sensitive services. Services which not only reflect but amplify and protect their cultural values and identity. The wider mental health system should openly accept the responsibility for assisting groups which in their program development assert the continuity and right of culture.

(7) In order to insure the system's current level of cultural sensitivity and diversity, the Ethnic Minority Concenrs Committee, in conjunction with the existing culturally sensitive ethnic minority mental health organizations and/or professionals should be entrusted with the task of soliciting "state of mental health" position statements from each significant ethnic group and preparing a "Charter of the Right of People to Culturally Sensitive Mental Health Services".

TABLES

The following Tables were taken from population figures based on data from the Population Research Unit, State of California publication "Provisional Projection of California Counties to 2000". The July, 1975, figures from that report were used. We acknowledge, however, the fact that these figures may have been underestimated for certain ethnic or racial groups.

Table I

California

Percent Of Total Asians/Pacific Islanders

CALIFORNIA
STATISTICS ON ASIANS/PACIFIC ISLANDERS
(%)

COUNTY	PERCENT OF TOTAL POPULATION
San Francisco	9.8%
Sacramento	3.0
Alameda	2.8
San Joaquin	2.6
Santa Clara	2.3
Fresno	2.1
Los Angeles	2.1
San Mateo	2.0
Yolo	2.0
Monterey	1.8
Santa Cruz	1.7
Sutter-Yuba	1.5
Placer	1.4
Contra Costa	1.3
Santa Barbara	1.1
Solano	1.1
San Luis Obispo	1.0
Marin	.9
Orange	.9
Ventura	.9
Colusa	.8
Imperial	.8
Kings	.8
Merced	.8
San Benito	.8
San Diego	.8
Tulare	.8
Madera	.7
Sonoma	.6
Kern	.5
Napa	.5
Butte	.4
Humboldt	.4
Mendocino	.4
Riverside	.4
San Bernardino	.4
Stanislaus	.4
Glenn	.3
Nevada	.3
Amador	.2
El Dorado	.2
Mariposa	.2
Shasta	.2
Tehama	.2

COUNTY	PERCENT OF TOTAL POPULATION
Del Norte	.1%
Inyo	.1
Lake	.1
Modoc	.1
Mono	.1
Plumas	.1
Siskiyou	.1
Trinity	.1
Tuolumne	.1
Lassen	.08
Calaveras	.05
Sierra	.04
Alpine	0

Table II

California

Percent Of Total Blacks

CALIFORNIA
STATISTICS ON BLACKS
(%)

COUNTY	PERCENT OF TOTAL POPULATION
Alameda	15.0%
San Francisco	13.4
Los Angeles	10.8
Solano	9.8
Contra Costa	7.4
Kern	5.7
Sacramento	5.7
San Joaquin	5.4
Merced	5.3
Kings	5.1
Fresno	4.9
Monterey	4.9
Madera	4.8
San Mateo	4.7
Riverside	4.6
San Diego	4.6
San Bernardino	4.3
Imperial	3.5
Amador	2.7
Sutter-Yuba	2.7
Santa Clara	2.6
Marin	2.5
Santa Barbara	2.4
San Luis Obispo	2.2
Siskiyou	2.1
Lassen	1.9
Plumas	1.7
Tulare	1.7
Ventura	1.7
Butte	1.6
Yolo	1.3
Tuolumne	1.2
Calaveras	1.0
Sonoma	1.0
Stanislaus	1.0
Shasta	.8
Colusa	.7
Orange	.7
Napa	.7
Santa Cruz	.7
Mendocino	.6
Humboldt	.5
Mariposa	.5
Placer	.5
Glenn	.3

COUNTY	PERCENT OF TOTAL POPULATION
Modoc	.3%
San Benito	.3
Tehama	.3
Alpine	.2
Del Norte	.2
Inyo	.2
Lake	.2
Sierra	.2
El Dorado	.1
Nevada	.1
Trinity	.05
Mono	0

Table III

California

Percent Of Total Chicanos/Spanish Speaking

CALIFORNIA
STATISTICS ON CHICANOS/SPANISH SPEAKING
(%)

COUNTY	PERCENT OF TOTAL POPULATION
Imperial	45.9%
San Benito	44.9
Tulare	26.1
Fresno	25.2
Kings	24.7
Madera	23.9
Merced	22.9
Monterey	21.0
Ventura	19.6
Los Angeles	18.3
San Joaquin	18.0
Santa Clara	17.5
Riverside	17.3
Santa Barbara	17.3
Colusa	17.1
Kern	16.8
Yolo	16.7
San Bernardino	16.0
Sierra	14.7
San Francisco	14.2
San Diego	12.8
Alameda	12.6
Stanislaus	12.6
Santa Cruz	11.8
Orange	11.3
San Mateo	11.3
San Luis Obispo	11.1
Solano	10.8
Glenn	10.6
Contra Costa	9.3
Placer	9.3
Sacramento	9.2
Sutter-Yuba	8.3
Lassen	7.8
Modoc	7.8
Amador	7.5
Napa	7.5
Sonoma	7.4
Inyo	7.3
Tuolomne	6.9
Marin	5.8
Tehama	5.8
Calaveras	5.6
Siskiyou	5.4
Butte	5.0

COUNTY	PERCENT OF TOTAL POPULATION
Mendocino	5.0%
Del Norte	4.6
Nevada	4.6
Lake	4.5
El Dorado	4.4
Humboldt	4.0
Plumas	3.8
Shasta	3.8
Mariposa	2.6
Trinity	2.2
Mono	1.2
Alpine	0

Table IV

California

Percent Of Total Whites

CALIFORNIA
STATISTICS ON WHITES
(%)

COUNTY	PERCENT OF TOTAL POPULATION
Nevada	94.4%
El Dorado	94.2
Mono	93.7
Trinity	93.3
Mariposa	93.1
Shasta	93.1
Lake	92.4
Tehama	92.0
Humboldt	91.6
Butte	91.3
Plumas	91.3
Mendocino	90.8
Marin	90.0
Calaveras	89.7
Napa	89.7
Del Norte	89.4
Sonoma	89.2
Tuolomne	88.9
Siskiyou	88.8
Modoc	88.6
Amador	87.8
Placer	87.8
Lassen	87.6
Glenn	87.2
Orange	86.0
Sutter-Yuba	84.8
Stanislaus	84.6
Inyo	84.4
Santa Cruz	83.9
San Luis Obispo	83.3
Sierra	81.5
Contra Costa	80.7
Sacramento	80.6
San Mateo	79.9
San Diego	79.4
Yolo	77.9
San Bernardino	77.7
Colusa	77.5
Santa Barbara	77.1
Santa Clara	76.8
Ventura	76.2
Riverside	75.8
Kern	74.4
Solano	74.4
Alpine	74.0
San Joaquin	70.1

COUNTY	PERCENT OF TOTAL POPULATION
Merced	69.3
Tulare	68.1
Alameda	67.2
Los Angeles	67.1
Monterey	67.0
Madera	66.8
Kings	66.6
Fresno	65.0
San Francisco	57.2
San Benito	51.4
Imperial	46.1

Table V

California

Number Of Total Population

Of Asians/Pacific Islanders

CALIFORNIA
STATISTICS ON ASIANS/PACIFIC ISLANDERS
(#)

COUNTY	TOTAL POPULATION	ASIAN/PACIFIC ISLANDER POPULATION
Los Angeles	7,004,597	147,097
San Francisco	665,000	65,170
Alameda	1,095,400	30,671
Santa Clara	1,198,896	27,575
Sacramento	702,795	21,084
Orange	1,755,595	15,800
San Diego	1,623,399	12,987
San Mateo	581,202	11,624
Fresno	462,500	9,713
San Joaquin	301,809	7,847
Contra Costa	597,912	7,773
Monterey	271,494	4,887
Ventura	452,501	4,073
Santa Barbara	286,298	3,149
San Bernardino	712,502	2,850
Santa Cruz	162,904	2,769
Riverside	543,013	2,172
Solano	192,895	2,122
Yolo	104,697	2,094
Marin	219,305	1,974
Kern	354,298	1,771
Tulare	213,401	1,707
Sonoma	253,303	1,520
Sutter-Yuba	93,898	1,408
Placer	95,697	1,340
San Luis Obispo	131,604	1,316
Merced	120,305	962
Stanislaus	230,895	924
Imperial	85,993	688
Kings	70,500	564
Butte	124,297	497
Napa	91,500	458
Humboldt	106,094	424
Madera	48,029	336
Mendocino	59,178	237
Shasta	95,204	190
San Benito	20,442	164
El Dorado	63,184	126
Nevada	36,404	109
Colusa	12,824	103
Tehama	32,791	66
Glenn	19,799	59

COUNTY	TOTAL POPULATION	ASIAN/PACIFIC ISLANDER POPULATION
Siskiyou	36,096	36
Amador	15,827	32
Lake	27,199	27
Tuolomne	27,198	27
Mariposa	8,880	18
Inyo	17,208	17
Del Norte	15,691	16
Lassen	18,484	15
Plumas	13,913	14
Trinity	10,095	10
Calaveras	16,046	8
Modoc	7,992	8
Mono	7,341	7
Sierra	2,992	1
Alpine	807	0

Table VI

California

Number of Total Population

Of Blacks

CALIFORNIA
STATISTICS ON BLACKS
(#)

COUNTY	TOTAL POPULATION	BLACK POPULATION
Los Angeles	7,004,597	756,496
Alameda	1,095,400	164,310
San Francisco	665,000	89,110
San Diego	1,623,399	74,676
Contra Costa	597,912	44,245
Sacramento	702,795	40,059
Santa Clara	1,198,896	31,171
San Bernardino	712,502	30,638
San Mateo	581,202	27,316
Riverside	543,013	24,979
Fresno	562,500	22,663
Kern	354,298	20,195
Solano	192,895	18,904
San Joaquin	301,809	16,298
Monterey	271,494	13,303
Orange	1,755,595	12,289
Ventura	452,501	7,693
Santa Barbara	286,298	6,871
Merced	120,305	6,376
Marin	219,305	5,483
Tulare	213,401	3,628
Kings	70,500	3,596
Imperial	85,993	3,010
San Luis Obispo	131,604	2,895
Sutter-Yuba	93,898	2,535
Sonoma	253,303	2,533
Stanislaus	230,895	2,309
Madera	48,029	2,305
Butte	124,297	1,989
Yolo	104,697	1,361
Santa Cruz	162,904	1,140
Shasta	95,204	762
Siskiyou	36,096	758
Napa	91,500	641
Humboldt	106,094	530
Placer	95,697	478
Amador	15,827	427
Mendocino	59,178	355
Lassen	18,484	351
Tuolumne	27,198	326
Plumas	13,913	237
Calaveras	16,046	160
Tehama	32,791	98
Colusa	12,824	90

COUNTY	TOTAL POPULATION	BLACK POPULATION
El Dorado	63,184	63
San Benito	20,442	61
Glenn	19,799	59
Lake	27,199	54
Mariposa	8,880	44
Nevada	36,404	36
Inyo	17,208	34
Del Norte	15,691	31
Modoc	7,992	24
Sierra	2,992	6
Trinity	10,095	5
Alpine	807	2
Mono	7,431	0

Table VII

California

Number Of Total Population

Of Chicanos/Spanish Speaking

CALIFORNIA
STATISTICS ON CHICANOS/SPANISH SPEAKING
(#)

COUNTY	TOTAL POPULATION	CHICANO/SPANISH SPEAKING POPULATION
Los Angeles	7,004,597	1,281,841
Santa Clara	1,198,896	209,897
San Diego	1,623,399	207,795
Orange	1,755,595	198,382
Alameda	1.095,400	138,020
Fresno	462,500	116,550
San Bernardino	712,502	114,000
Riverside	543,013	93,941
Ventura	452,501	88,690
San Mateo	581,202	65,676
Sacramento	702,795	64,657
Kern	354,298	59,522
Monterey	271,494	57,014
Tulare	213,401	55,698
Contra Costa	517,912	55,606
San Joaquin	301,809	54,326
Santa Barbara	286,298	49,530
Imperial	85,993	39,471
Stanislaus	230,895	29,093
Merced	120,305	27,550
Solano	192,895	20,883
Santa Cruz	162,904	19,223
Sonoma	253,303	18,744
Yolo	104,697	17,484
Kings	70,500	17,414
San Luis Obispo	131,604	14,608
Marin	219,305	12,720
Madera	48,029	11,479
San Francisco	655,000	9,301
San Benito	20,442	9.178
Placer	95,697	8,900
Sutter-Yuba	93,898	7,794
Napa	91,500	6,863
Butte	124,297	6,215
Humboldt	106,094	4,244
Shasta	95,204	3,618
Mendocino	59,178	2,959
El Dorado	63,184	2,780
Colusa	12,824	2,193
Glenn	19,799	2,099
Siskiyou	36,096	1,949
Tehama	32,791	1,902
Tuolomne	27,198	1,877
Nevada	36,404	1,675
Lassen	18,484	1,442
Inyo	17,208	1,256

COUNTY	TOTAL POPULATION	CHICANO/SPANISH SPEAKING POPULATIO
Lake	27,199	1,224
Amador	15,827	1,187
Calaveras	16,046	899
Del Norte	15,691	722
Modoc	7,992	623
Plumas	13,913	529
Sierra	2,992	440
Mariposa	8,880	231
Trinity	10,095	55
Mono	7,341	88
Alpine	807	0

Table VIII

California

Number Of Total Population

Of Whites

CALIFORNIA
STATISTICS ON WHITES
(#)

COUNTY	TOTAL POPULATION	WHITE POPULATION
Los Angeles	7,004,597	4,700,085
Orange	1,755,595	1,509,812
San Diego	1,623,399	1,288,979
Santa Clara	1,981,896	920,075
Alameda	1,095,400	736,109
Sacramento	702,795	566,453
San Bernardino	712,502	553,614
Contra Costa	597,912	582,515
San Mateo	581,202	464,380
Riverside	543,013	411,604
San Francisco	665,000	380,380
Ventura	452,501	344,806
Fresno	462,500	300,625
Kern	354,298	263,598
Sonoma	253,303	225,946
Santa Barbara	286,298	220,736
San Joaquin	301,809	211,568
Marin	219,305	197,375
Stanislaus	230,895	195,337
Monterey	271,494	181,901
Tulare	213,401	145,326
Solano	192,895	143,514
Santa Cruz	162,904	136,676
Butte	124,297	113,483
San Luis Obispo	131,604	109,626
Humboldt	106,094	97,182
Shasta	95,204	88,635
Placer	95,697	84,022
Merced	120,305	83,371
Napa	91,500	82,076
Yolo	104,697	81,559
Sutter-Yuba	93,898	79,626
El Dorado	63,184	59,519
Mendocino	59,178	53,734
Kings	70,500	46,953
Imperial	85,993	36,643
Nevada	36,404	34,365
Madera	48,029	32,083
Siskiyou	36,096	32,053
Tehama	32,791	30,168
Lake	27,199	25,132
Tuolumne	27,198	24,179

COUNTY	TOTAL POPULATION	WHITE POPULATION
Glenn	19,799	17,265
Lassen	18,484	16,192
Inyo	17,208	14,524
Calaveras	16,046	14,393
Del Norte	15,691	14,298
Amador	15,827	13,986
Plumas	13,913	12,703
San Benito	20,442	10,507
Colusa	12,824	9,939
Trinity	10,095	9,419
Mariposa	8,880	8,267
Modoc	7,992	7,081
Mono	7,341	6,879
Sierra	2,992	2,438
Alpine	807	597

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